State of Wisconsin
2017 - 2018 LEGISLATURE

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ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO ASSEMBLY BILL 365

June 21, 2017 – Offered by Representatives PETERSEN and SANFELIPPO.

AN ACT ***to repeal*** 632.746 (1) (b), 632.746 (2) (c), (d) and (e), 632.746 (3) (a), 632.746 (3) (d) 2. and 3., 632.746 (5) and 632.76 (2) (ac) 3.; ***to renumber*** 632.746 (3) (d) 1.; ***to renumber and amend*** 632.746 (1) (a); ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 625.12 (1) (a), 625.12 (1) (e), 625.12 (2), 625.15 (1), 628.34 (3) (a), 632.746 (2) (a), 632.746 (8) (a) (intro.), 632.76 (2) (a) and (ac) 1. and 2., 632.795 (4) (a) and 632.897 (11) (a); and ***to create*** 609.847 and 632.728 of the statutes; **relating to:** coverage of individuals with preexisting conditions.

Analysis by the Legislative Reference Bureau

This substitute amendment prohibits a group health benefit plan, including a self–insured governmental health plan, from imposing a preexisting condition exclusion. The substitute amendment also prohibits an individual health insurance policy, known in the substitute amendment as a disability insurance policy, from reducing or denying a claim or loss incurred or disability commencing under the policy on the ground that a disease or physical condition existed prior to the effective date of coverage. The substitute amendment also prohibits a group or individual

health insurance policy or a self–insured governmental health plan from considering whether an individual, including a dependent, who has continuous coverage and who would be covered under the plan has a preexisting condition for the purpose of setting any premiums, deductibles, copayments, or coinsurance under the policy or plan. The substitute amendment allows the commissioner of insurance to propose a plan to assist individuals who have preexisting conditions in maintaining or purchasing coverage. The commissioner's plan must include expanded choices of insurance coverage, more affordable options for individuals to purchase coverage, and greater flexibility in portability of coverage. The commissioner shall submit the plan to the Joint Committee on Finance for review under its passive review process. The plan, if implemented, would supersede other state insurance statutes to the extent they are inconsistent.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.728, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 2. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.728, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.885, 632.89, and 632.895 (11) to (17).

SECTION 3. 66.0137 (4) of the statutes is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis,

the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.746 (1), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.746 (1), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 5. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.728, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (2), (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 6. 609.847 of the statutes is created to read:

609.847 Preexisting condition discrimination prohibited. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.728.

SECTION 7. 625.12 (1) (a) of the statutes is amended to read:

625.12 **(1)** (a) Past and prospective loss and expense experience within and outside of this state, except as provided in s. 632.728.

SECTION 8. 625.12 (1) (e) of the statutes is amended to read:

625.12 **(1)** (e) Subject to ~~s.~~ ss. 632.365 and 632.728, all other relevant factors, including the judgment of technical personnel.

SECTION 9. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. ~~Risks~~ Except as provided in s. 632.728, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classifications may be based on race, color, creed or national origin, and classifications in automobile insurance may not be based on physical condition or developmental disability as defined in s. 51.01 (5). Subject to ~~s.~~ ss. 632.365 and 632.728, rates thus produced may be modified for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards, expenses, or both. Rates may also be modified for individual risks under s. 625.13 (2).

SECTION 10. 625.15 (1) of the statutes is amended to read:

625.15 **(1)** RATE MAKING. ~~An~~ Except as provided in s. 632.728, an insurer may itself establish rates and supplementary rate information for one or more market segments based on the factors in s. 625.12 and, if the rates are for motor vehicle liability insurance, subject to s. 632.365, or the insurer may use rates and supplementary rate information prepared by a rate service organization, with average expense factors determined by the rate service organization or with such modification for its own expense and loss experience as the credibility of that experience allows.

SECTION 11. 628.34 (3) (a) of the statutes is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the

basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ss. 632.365, 632.728, 632.746 and 632.748. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

SECTION 12. 632.728 of the statutes is created to read:

632.728 Coverage of individuals with preexisting conditions. (1) In this section:

(a) "Continuous coverage" means creditable coverage, as defined in 632.745 (4), in the 12–month period before the date of enrollment in coverage and during which there is no period longer than 63 continuous days during which the applicant for coverage did not have creditable coverage.

(b) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(c) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) (a) For the purpose of setting rates or premiums for coverage under a group or individual disability insurance policy or a self–insured health plan and for the purpose of setting any deductibles, copayments, or coinsurance under a group or individual disability insurance policy or a self–insured health plan, the policy or plan may not consider whether an individual, including a dependent, who has continuous coverage and who would be covered under the policy or plan has a preexisting condition.

(b) The commissioner may propose a plan to assist individuals who have not maintained continuous coverage and who have preexisting conditions in purchasing coverage. The commissioner's plan under this paragraph shall include expanded choices of insurance coverage, more affordable options for individuals to purchase

coverage, and greater flexibility in portability of coverage. The commissioner shall submit the plan under this paragraph to the joint committee on finance for review. If, within 14 days after the date of the commissioner's submission, the cochairpersons of the committee do not notify the commissioner that the committee has scheduled a meeting to review the plan, the commissioner may take actions necessary to implement the plan. If the cochairpersons notify the commissioner that the committee has scheduled a meeting to review the plan, the commissioner may take actions necessary to implement the plan only upon the approval of the committee. A plan implemented under this paragraph supersedes ss. 632.746 and 632.76 and any other section in chs. 600 to 655 to the extent that the plan is inconsistent with that section.

(3) Nothing in this subchapter shall be construed as permitting health insurance issuers to limit access to health insurance coverage for individuals with preexisting conditions.

SECTION 13. 632.746 (1) (a) of the statutes is renumbered 632.746 (1) and amended to read:

632.746 **(1)** ~~Subject to subs. (2) and (3), an~~ An insurer that offers a group health benefit plan may~~, with respect to a participant or beneficiary under the plan,~~ not impose a preexisting condition exclusion ~~only if the exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6–month period ending on the participant's or beneficiary's enrollment date under the plan~~ on a participant or beneficiary under the plan.

SECTION 14. 632.746 (1) (b) of the statutes is repealed.

SECTION 15. 632.746 (2) (a) of the statutes is amended to read:

632.746 **(2)** (a) An insurer offering a group health benefit plan may not treat genetic information as a preexisting condition under sub. (1) ~~without a diagnosis of a condition related to the information~~.

SECTION 16. 632.746 (2) (c), (d) and (e) of the statutes are repealed.

SECTION 17. 632.746 (3) (a) of the statutes is repealed.

SECTION 18. 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

SECTION 19. 632.746 (3) (d) 2. and 3. of the statutes are repealed.

SECTION 20. 632.746 (5) of the statutes is repealed.

SECTION 21. 632.746 (8) (a) (intro.) of the statutes is amended to read:

632.746 **(8)** (a) (intro.) A health maintenance organization that offers a group health benefit plan ~~and that does not impose any preexisting condition exclusion under sub. (1)~~ with respect to a particular coverage option may impose an affiliation period for that coverage option, but only if all of the following apply:

SECTION 22. 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a group health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance policy, as defined in s. 632.895 (1) (a), or a self–insured health plan, as defined in s. 632.85 (1) (c).

(ac) 1. ~~Notwithstanding par. (a), no~~ No claim or loss incurred or disability commencing ~~after 12 months from the date of issue of~~ under an individual disability insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the

ground that a disease or physical condition existed prior to the effective date of coverage~~, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss~~.

2. ~~Except as provided in subd. 3., an~~ An individual disability insurance policy, as defined in s. 632.895 (1) (a), ~~other than a short–term policy subject to s. 632.7495 (4) and (5),~~ may not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received ~~within 12 months before the effective date of coverage~~.

SECTION 23. 632.76 (2) (ac) 3. of the statutes is repealed.

SECTION 24. 632.795 (4) (a) of the statutes is amended to read:

632.795 **(4)** (a) An insurer subject to sub. (2) shall provide coverage under the same policy form and for the same premium as it originally offered in the most recent enrollment period, subject only to the medical underwriting used in that enrollment period. Unless otherwise prescribed by rule, the insurer may apply deductibles, ~~preexisting condition limitations,~~ waiting periods, or other limits only to the extent that they would have been applicable had coverage been extended at the time of the most recent enrollment period and with credit for the satisfaction or partial satisfaction of similar provisions under the liquidated insurer's policy or plan. The insurer may exclude coverage of claims that are payable by a solvent insurer under insolvency coverage required by the commissioner or by the insurance regulator of another jurisdiction. Coverage shall be effective on the date that the liquidated insurer's coverage terminates.

SECTION 25. 632.897 (11) (a) of the statutes is amended to read:

632.897 **(11)** (a) Notwithstanding subs. (2) to (10), the commissioner may promulgate rules establishing standards requiring insurers to provide continuation of coverage for any individual covered at any time under a group policy who is a terminated insured or an eligible individual under any federal program that provides for a federal premium subsidy for individuals covered under continuation of coverage under a group policy, including rules governing election or extension of election periods, notice, rates, premiums, premium payment, ~~application of preexisting condition exclusions,~~ election of alternative coverage, and status as an eligible individual, as defined in s. 149.10 (2t), 2011 stats.

SECTION 26. Initial applicability.

(1) PREEXISTING CONDITIONS.

(a) For policies and plans containing provisions inconsistent with this act, the act first applies to policy or plan years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in paragraph (b).

(b) For policies or plans that are affected by a collective bargaining agreement containing provisions inconsistent with this act, this act first applies to policy or plan years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 27. Effective date.

(1) This act takes effect on the first day of the 4th month beginning after publication.

(END)