State of Wisconsin
2009 - 2010 LEGISLATURE

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2009 SENATE BILL 466

January 22, 2010 - Introduced by Senators ERPENBACH, RISSER, HANSEN, HOLPERIN and DARLING, cosponsored by Representatives DEXTER, POCAN, POPE-ROBERTS, BERCEAU and A. WILLIAMS. Referred to Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

AN ACT ***to repeal*** 632.895 (16) (a) 4.; ***to renumber*** 631.95 (5) (a) and 632.87 (1); ***to renumber and amend*** 632.745 (9), 632.745 (24), 632.83 (1) and 632.85 (1) (c); ***to amend*** 66.0137 (4), 120.13 (2) (g), 153.01 (5m), 601.41 (8) (a) 1., 601.42 (1g) (intro.), 601.42 (4), 601.43 (1) (a), 601.43 (1) (d), 601.64 (1), 601.64 (3) (a), 601.64 (3) (c), 601.64 (4), 627.23 (2), 631.90 (2) (intro.), 631.90 (2) (b), 631.90 (2) (c), 631.93 (2), 631.95 (4), 631.95 (5) (c) (intro.), 632.726 (2), 632.745 (intro.), 632.745 (15), 632.835 (1) (c), 632.845 (2), 632.857, 632.86 (2) (intro.), 632.88 (1) (intro.), 632.88 (2), 632.895 (2) (a), (d) and (e), 632.895 (3), 632.895 (4) (a), 632.895 (4) (c), 632.895 (5) (a), (b), (c) and (d), 632.895 (5m), 632.895 (6) and (7), 632.895 (8) (b) 1. (intro.) and 2., (c), (d) and (e) (intro.), 632.895 (9) (b) (intro.), 632.895 (9) (c), 632.895 (10) (a), 632.895 (11) (a) (intro.) and (d), 632.895 (12) (b) (intro.), 632.895 (12) (c), 632.895 (13) (a), 632.895 (14) (b), 632.895 (15) (a), 632.895 (16) (c) 2., 632.895 (17) (b) (intro.), 632.895 (17) (d) 2., 632.896 (2), 632.896 (3) (a) 2., 632.896 (4), 632.896 (6), 635.02 (3k) and 646.01 (1) (b) 9.; and

to create 623.17, 627.23 (6), 631.95 (2m), 631.95 (5) (ag), 632.745 (9) (c), 632.83 (1) (b), 632.83 (1) (c), 632.835 (1) (cg), 632.835 (1) (ck), 632.87 (1g), 632.875 (1) (bg), 632.875 (1) (cg), 632.89 (1) (bm), 632.89 (1) (dg), 632.895 (1) (e), 632.895 (1) (f), 632.895 (1) (g), 632.896 (1) (bg), 632.896 (1) (bk), 632.896 (1) (d), 645.02 (8), 646.01 (1) (a) 3. and 646.03 (2q) of the statutes; **relating to:** regulation by the office of the commissioner of insurance of self–insured health plans offered by a city, town, village, county, or school district, providing a penalty, and granting rule–making authority.

Analysis by the Legislative Reference Bureau

Under current law, a city, village, town, county, or school district may offer a self–insured health plan (self–insured governmental health plan) to its employees. The Office of the Commissioner of Insurance (OCI) may enforce laws that specify some of the coverage a self–insured governmental health plan must offer. Current law requires that a self–insured governmental health plan must offer coverage to all eligible employees and their dependents and dictates other requirements for plan participation. Current law also mandates coverage that a self–insured governmental health plan must offer, such as drugs for treatment of human immunodeficiency virus (HIV), lead poisoning screening, treatment for the correction of temporomandibular disorders, anesthetic and surgery center charges in conjunction with dental care, breast reconstruction if the plan also covers mastectomy, certain immunizations, and health care for students on medical leave. Current law requires that if a self–insured governmental health plan covers dependent children, the plan must also cover adopted children. Among other requirements, self–insured governmental health plans must develop procedures for physicians to request an exception for a plan participant for drugs or devices that are routinely not covered under the plan, must specify any limits on coverage of experimental treatment, may not require preauthorization for emergency services if the plan covers emergency services, and may not exclude coverage for treatment of a condition by a dentist if the treatment is covered when performed by another health care provider.

This bill expands the authority of OCI to regulate a self–insured health plan of a city, village, town, county, or school district (governmental body), similar to the way OCI currently regulates insurers offering a health insurance policy or group health benefit plan. The bill allows OCI to require a governmental body that provides a self–insured health plan to provide reports pertaining to the self–insured health plan and to reply to requests for information made to a person with authority over the self–insured health plan. OCI may examine the affairs of the governmental body

as they relate to the self–insured health plan. The bill allows OCI to seek an injunction or temporary restraining order for a violation of the statutes pertaining to a self–insured governmental health plan and allows forfeitures and criminal penalties to be imposed for those violations. OCI must promulgate rules regarding the level of reserves and surpluses that the governmental body must maintain with respect to its self–insured health plan. The governmental body may reinsure the self–insured health plan under this bill but must report the name of the reinsurer to OCI. The bill applies laws pertaining to rehabilitation and liquidation of insurers and the insurance security fund to governmental bodies, with respect to a self–insured health plan.

The bill imposes coverage requirements on self–insured governmental health plans similar to requirements imposed on health insurance policies and group health benefit plans. Self–insured governmental health plans, under the bill, may not limit coverage of HIV treatment if limits are not imposed on other illnesses or medical conditions, may not refuse to provide or renew coverage based on the health plan participant being a victim of domestic violence, must establish an internal grievance procedure and an independent review plan for the review of adverse and experimental treatment determinations, may not exclude coverage of treatment by a licensed chiropractor, must provide an explanation for a restriction or termination of coverage, must cover home care in certain circumstances, must cover skilled nursing care meeting certain requirements, must cover maternity and newborn children, must cover diabetes treatment and diabetic supplies, may not deny coverage based on possible coverage under a liability policy, and must cover mammograms, among other requirements.

Because this bill creates a new crime or revises a penalty for an existing crime, the Joint Review Committee on Criminal Penalties may be requested to prepare a report concerning the proposed penalty and the costs or savings that are likely to result if the bill is enacted.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28, 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),

631.95, 632.726, 632.746 ~~(10) (a) 2. and (b) 2.~~, 632.747 (3), 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.857, 632.86, 632.87 ~~(4), (5), and (6)~~, 632.875, 632.88, 632.885, 632.89, 632.895 ~~(9) to (17)~~, 632.896, 632.897, and 767.513 (4).

SECTION 2. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28, 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), 631.95, 632.726, 632.746 ~~(10) (a) 2. and (b) 2.~~, 632.747 (3), 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.857, 632.86, 632.87 ~~(4), (5), and (6)~~, 632.875, 632.88, 632.885, 632.89, 632.895 ~~(9) to (17)~~, 632.896, 632.897, and 767.513 (4).

SECTION 3. 153.01 (5m) of the statutes is amended to read:

153.01 **(5m)** "Insurer" has the meaning given under s. 632.745 (15) but does not include a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 4. 601.41 (8) (a) 1. of the statutes is amended to read:

601.41 **(8)** (a) 1. "Group health benefit plan" has the meaning given in s. 632.745 (9) (a) and (b).

SECTION 5. 601.42 (1g) (intro.) of the statutes is amended to read:

601.42 **(1g)** REPORTS. (intro.) The commissioner may require any of the following from any person subject to regulation under chs. 600 to 655 and from any city, village, town, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan:

SECTION 6. 601.42 (4) of the statutes is amended to read:

601.42 **(4)** REPLIES. Any officer, manager or general agent of any insurer authorized to do or doing an insurance business in this state, any person controlling

or having a contract under which the person has a right to control such an insurer, whether exclusively or otherwise, any person with executive authority over or in charge of any segment of such an insurer's affairs, any person with authority over or in charge of a self–insured health plan of a city, town, village, county or school district, any individual practice association or officer, director or manager of an individual practice association, any insurance agent or other person licensed under chs. 600 to 646, any provider of services under a continuing care contract, as defined in s. 647.01 (2), any independent review organization certified or recertified under s. 632.835 (4) or any health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other designated form, to any written inquiry from the commissioner requesting a reply.

SECTION 7. 601.43 (1) (a) of the statutes is amended to read:

601.43 **(1)** (a) *Insurers, other licensees and other persons subject to regulation.* Whenever the commissioner deems it necessary in order to inform himself or herself about any matter related to the enforcement of chs. 600 to 647, the commissioner may examine the affairs and condition of any licensee or permittee under chs. 600 to 647 or applicant for a license or permit, of any person or organization of persons doing or in process of organizing to do an insurance business in this state, of any city, village, town, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan, and of any advisory organization serving any of the foregoing in this state.

SECTION 8. 601.43 (1) (d) of the statutes is amended to read:

601.43 **(1)** (d) *Delivery of records to the office.* On order of the commissioner any licensee or permittee under chs. 600 to 647, or a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured

health plan, shall bring to the office for examination such records as the order reasonably requires.

SECTION 9. 601.64 (1) of the statutes is amended to read:

601.64 **(1)** INJUNCTIONS AND RESTRAINING ORDERS. The commissioner may commence an action in circuit court in the name of the state to restrain by temporary or permanent injunction or by temporary restraining order any violation of chs. 600 to 655 or s. 59.52 (11) (c), 66.0137 (4) or (4m), 120.13 (2) (b) to (g), or 149.13, any rule promulgated under chs. 600 to 655, or any order issued under s. 601.41 (4). The commissioner need not show irreparable harm or lack of an adequate remedy at law in an action commenced under this subsection.

SECTION 10. 601.64 (3) (a) of the statutes is amended to read:

601.64 **(3)** (a) *Restitutionary forfeiture.* Whoever violates an effective order issued under s. 601.41 (4), any insurance statute or rule, or s. 59.52 (11) (c), 66.0137 (4) or (4m), 120.13 (2) (b) to (g), or 149.13 shall forfeit to the state twice the amount of any profit gained from the violation, in addition to any other forfeiture or penalty imposed.

SECTION 11. 601.64 (3) (c) of the statutes is amended to read:

601.64 **(3)** (c) *Forfeiture for violation of statute or rule.* Whoever violates an insurance statute or rule or s. 149.13, intentionally aids a person in violating an insurance statute or rule or s. 59.52 (11) (c), 66.0137 (4) or (4m), 120.13 (2) (b) to (g), or 149.13, or knowingly permits a person over whom he or she has authority to violate an insurance statute or rule or s. 149.13 shall forfeit to the state not more than $1,000 for each violation. If the statute or rule imposes a duty to make a report to the commissioner, each week of delay in complying with the duty is a new violation.

SECTION 12. 601.64 (4) of the statutes is amended to read:

601.64 **(4)** CRIMINAL PENALTY. Whoever intentionally violates or intentionally permits any person over whom he or she has authority to violate or intentionally aids any person in violating any insurance statute or rule of this state, s. 59.52 (11) (c), 66.0137 (4) or (4m), 120.13 (2) (b) to (g), or 149.13, or any effective order issued under s. 601.41 (4) is guilty of a Class I felony, unless a specific penalty is provided elsewhere in the statutes. Intent has the meaning expressed under s. 939.23.

SECTION 13. 623.17 of the statutes is created to read:

623.17 Self–insured governmental health plans. (1) The commissioner shall promulgate rules regarding the level of reserves, compulsory surplus, and security surplus that must be maintained by a city, village, town, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

(2) The commissioner may order a city, village, town, county, or school district to adjust its reserves or surpluses if they do not bear an appropriate relation to its obligations with regard to a self–insured health plan.

(3) A city, village, town, county, or school district that provides a self–insured health plan shall do all of the following:

(a) Comply with rules promulgated and orders issued under this section.

(b) Report to the commissioner annually the levels of reserves and surpluses maintained with respect to a self–insured health plan.

SECTION 14. 627.23 (2) of the statutes is amended to read:

627.23 **(2)** POWER TO CEDE REINSURANCE. Subject to s. 611.78, any authorized insurer or a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan, may cede to any insurer authorized to assume it under chs. 611 to 618 and sub. (1) any liability it has

undertaken on risks lawfully written under its certificate of authority. It may also cede reinsurance to any authorized agency of the federal government or of this state. Subject to rules promulgated by the commissioner for calculation of its reserves and its surplus, and subject to sub. (3), an authorized insurer may also cede reinsurance to an unauthorized insurer.

SECTION 15. 627.23 (6) of the statutes is created to read:

627.23 **(6)** REINSURANCE OF SELF–INSURED HEALTH PLANS. A city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan, shall report annually to the commissioner the name of any reinsurer.

SECTION 16. 631.90 (2) (intro.) of the statutes is amended to read:

631.90 **(2)** (intro.) With regard to policies or plans issued or renewed on and after July 20, 1985, an insurer or self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3., may not do any of the following:

SECTION 17. 631.90 (2) (b) of the statutes is amended to read:

631.90 **(2)** (b) Condition the provision of insurance or plan coverage on whether an individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or what the results of this test, if obtained by the individual, were.

SECTION 18. 631.90 (2) (c) of the statutes is amended to read:

631.90 **(2)** (c) Consider in the determination of rates or any other aspect of insurance or plan coverage provided to an individual whether an individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or what the results of this test, if obtained by the individual, were.

SECTION 19. 631.93 (2) of the statutes is amended to read:

631.93 **(2)** ACCIDENT AND HEALTH INSURANCE. An accident or health insurance policy or self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3., may not contain exclusions or limitations, including deductibles or copayments, for coverage of the treatment of HIV infection or any illness or medical condition arising from or related to HIV infection, unless the exclusions or limitations apply generally to other illnesses or medical conditions covered by the policy or plan.

SECTION 20. 631.95 (2m) of the statutes is created to read:

631.95 **(2m)** PROHIBITIONS AND EXCEPTIONS FOR SELF–INSURED HEALTH PLANS. (a) In this subsection, "self–insured governmental body" means a city, town, village, county, or school district that provides a self–insured health plan, with respect to the health plan.

(b) Except as provided in par. (c), a self–insured governmental body may not do any of the following:

1. Refuse to provide or renew coverage to a health plan participant under the self–insured health plan on the basis that the health plan participant has been, or the self–insured governmental body has reason to believe that the health plan participant is, a victim of abuse or domestic abuse or that a member of the health plan participant's family has been, or the self–insured governmental body has reason to believe that a member of the health plan participant's family is, a victim of abuse or domestic abuse.

2. Use as a factor in the determination of employee contributions or any other aspect of coverage under the self–insured health plan, the knowledge or suspicion that a health plan participant has been or is a victim of abuse or domestic abuse or that a member of the health plan participant's family has been or is a victim of abuse or domestic abuse.

3. Exclude or limit coverage of, or deny a claim for, health care services or items related to the treatment of injury or disease resulting from abuse or domestic abuse on the basis that a health plan participant has been, or the self–insured governmental body has reason to believe that a health plan participant is, a victim of abuse or domestic abuse or that a member of the health plan participant's family has been, or the self–insured governmental body has reason to believe that a member of the health plan participant's family is, a victim of abuse or domestic abuse.

(c) In establishing any employee contribution amounts for a self–insured health plan, a self–insured governmental body may inquire about a person's existing medical condition and, based on the opinion of a qualified actuary, as defined in s. 623.06 (1c), use information related to a person's existing medical condition, regardless of whether that condition is or may have been caused by abuse or domestic abuse.

SECTION 21. 631.95 (4) of the statutes is amended to read:

631.95 **(4)** IMMUNITY FOR INSURERS. An insurer or a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan, is immune from any civil or criminal liability for any action taken under sub. (2m) (c) or (3) or for the death of, or injury to, an insured or health plan participant that results from abuse or domestic abuse.

SECTION 22. 631.95 (5) (a) of the statutes is renumbered 631.95 (5) (ar).

SECTION 23. 631.95 (5) (ag) of the statutes is created to read:

631.95 **(5)** (ag) In this subsection, unless the context requires otherwise:

1. "Insurance" includes a self–insured health plan of a city, town, village, county, or school district.

2. "Insured" includes a person who participates in a self–insured health plan provided by a city, town, village, county, or school district.

3. "Insurer" includes a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 24. 631.95 (5) (c) (intro.) of the statutes is amended to read:

631.95 **(5)** (c) (intro.) Paragraphs ~~(a)~~ (ar) and (b) do not apply if the use, disclosure or transfer of the information is made with the consent of the individual to whom the information relates or if the use, disclosure or transfer satisfies any of the following:

SECTION 25. 632.726 (2) of the statutes is amended to read:

632.726 **(2)** If an insurer or a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan, changes a current procedural terminology code that was submitted by a health care provider on a health insurance claim form, the insurer or city, town, village, county, or school district shall include on the explanation of benefits form the reason for the change to the current procedural terminology code and shall cite on the explanation of benefits form the source for the change.

SECTION 26. 632.745 (intro.) of the statutes is amended to read:

632.745 Coverage requirements for group and individual health benefit plans; definitions. (intro.) In this section and ss. 632.746 to 632.7495, unless the context requires otherwise:

SECTION 27. 632.745 (9) of the statutes is renumbered 632.745 (9) (intro.) and amended to read:

632.745 **(9)** (intro.) "Group health benefit plan" means ~~a~~ any of the following:

(a) A health benefit plan that is issued by an insurer to or through an employer on behalf of a group consisting of at least 2 employees or a group including at least 2 eligible employees. ~~The term includes individual~~

(b) Individual health benefit plans covering eligible employees when 3 or more are sold to or through an employer.

SECTION 28. 632.745 (9) (c) of the statutes is created to read:

632.745 **(9)** (c) A self–insured health plan under sub. (24) (b) and (c).

SECTION 29. 632.745 (15) of the statutes is amended to read:

632.745 **(15)** "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers health benefit plans covering individuals in this state or eligible employees of one or more employers in this state. The term includes a health maintenance organization, a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan, and a limited service health organization, as defined in s. 609.01 (3).

SECTION 30. 632.745 (24) of the statutes is renumbered 632.745 (24) (intro.) and amended to read:

632.745 **(24)** "Self–insured health plan" means a self–insured health plan of ~~the~~ any of the following:

(a) The state ~~or a~~ .

(b) A county, city, village, or town ~~or.~~

(c) A school district.

SECTION 31. 632.83 (1) of the statutes is renumbered 632.83 (1) (intro.) and amended to read:

632.83 **(1)** In this section~~, "health~~:

(a) "Health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10. and includes a self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3., and a policy, certificate or contract under s. 632.745 (11) (b) 9. that provides only limited–scope dental or vision benefits.

SECTION 32. 632.83 (1) (b) of the statutes is created to read:

632.83 **(1)** (b) "Insured" includes a person who participates in a self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3.

SECTION 33. 632.83 (1) (c) of the statutes is created to read:

632.83 **(1)** (c) "Insurer" includes a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 34. 632.835 (1) (c) of the statutes is amended to read:

632.835 **(1)** (c) "Health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10. and a self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3.

SECTION 35. 632.835 (1) (cg) of the statutes is created to read:

632.835 **(1)** (cg) "Insured" includes a person who participates in a self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3.

SECTION 36. 632.835 (1) (ck) of the statutes is created to read:

632.835 **(1)** (ck) "Insurer" includes a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 37. 632.845 (2) of the statutes, as created by 2009 Wisconsin Act 28, is amended to read:

632.845 **(2)** ~~An~~ A self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3. or an insurer that provides coverage under a health care plan may not refuse to cover health care services that are provided to an insured under the plan and for which there is coverage under the plan on the basis that there may be coverage for the services under a liability insurance policy.

SECTION 38. 632.85 (1) (c) of the statutes is renumbered 632.85 (1) (c) (intro.) and amended to read:

632.85 **(1)** (c) "Self–insured health plan" means a self–insured health plan of ~~the~~ any of the following:

1. The state ~~or a .~~

2. A county, city, village, or town ~~or.~~

3. A school district.

SECTION 39. 632.857 of the statutes is amended to read:

632.857 Explanation required for restriction or termination of coverage. If an insurer or a self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3., restricts or terminates an insured's or a health plan participant's coverage for the treatment of a condition or complaint and, as a result, the insured or health plan participant becomes liable for payment for all of his or her treatment for the condition or complaint, the insurer or self–insured health plan shall provide on the explanation of benefits form a detailed explanation of the clinical rationale and of the

basis in the policy, plan, or contract or in applicable law for the insurer's or self–insured health plan's restriction or termination of coverage.

SECTION 40. 632.86 (2) (intro.) of the statutes is amended to read:

632.86 **(2)** No group or blanket disability insurance policy or self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3., that provides coverage of prescribed drugs or devices through a pharmaceutical mail order plan may do any of the following:

SECTION 41. 632.87 (1) of the statutes is renumbered 632.87 (1r).

SECTION 42. 632.87 (1g) of the statutes is created to read:

632.87 **(1g)** In this section, unless the context requires otherwise:

(a) "Insured" includes a person who participates in a self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3.

(b) "Insurer" includes a city, town, village, county, or school district that provides a self–insured health plan, with respect to that self–insured health plan.

(c) "Plan" includes a self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3.

SECTION 43. 632.875 (1) (bg) of the statutes is created to read:

632.875 **(1)** (bg) "Insurer" includes a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 44. 632.875 (1) (cg) of the statutes is created to read:

632.875 **(1)** (cg) "Plan" includes a self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3.

SECTION 45. 632.88 (1) (intro.) of the statutes is amended to read:

632.88 **(1)** TERMINATION OF COVERAGE. (intro.) Every hospital or medical expense insurance policy or contract or self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3., that provides that coverage of a dependent child of a person insured under the policy or covered under the plan shall terminate upon attainment of a limiting age for dependent children specified in the policy or plan shall also provide that the age limitation may not operate to terminate the coverage of a dependent child while the child is and continues to be both:

SECTION 46. 632.88 (2) of the statutes is amended to read:

632.88 **(2)** PROOF OF INCAPACITY. The insurer or self–insured health plan, as defined in s. 632.85 (1) (c) 2. and 3., may require that proof of the incapacity and dependency be furnished by the person insured under the policy or participating in the self–insured health plan within 31 days of the date the child attains the limiting age, and at any time thereafter except that the insurer or self–insured health plan may not require proof more frequently than annually after the 2–year period immediately following attainment of the limiting age by the child.

SECTION 47. 632.89 (1) (bm) of the statutes is created to read:

632.89 **(1)** (bm) "Group or blanket disability insurance policy" includes a self–insured health plan, as defined in 632.85 (1) (c) 2. and 3.

SECTION 48. 632.89 (1) (dg) of the statutes is created to read:

632.89 **(1)** (dg) "Insurer" includes a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 49. 632.895 (1) (e) of the statutes is created to read:

632.895 **(1)** (e) "Insured" includes a person who participates in a self–insured health plan.

SECTION 50. 632.895 (1) (f) of the statutes is created to read:

632.895 **(1)** (f) "Insurer" includes a city, town, village, county, or school district that provides a self–insured health plan, with respect to that self–insured health plan.

SECTION 51. 632.895 (1) (g) of the statutes is created to read:

632.895 **(1)** (g) "Self–insured health plan" means a self–insured health plan of any of the following:

1. The state.

2. A county, city, village, or town.

3. A school district.

SECTION 52. 632.895 (2) (a), (d) and (e) of the statutes are amended to read:

632.895 **(2)** (a) Every disability insurance policy or self–insured health plan under sub. (1) (g) 2. and 3. which provides coverage of expenses incurred for inpatient hospital care shall provide coverage for the usual and customary fees for home care. Such coverage shall be subject to the same deductible and coinsurance provisions of the policy or self–insured health plan as other covered services. The maximum weekly benefit for such coverage need not exceed the usual and customary weekly cost for care in a skilled nursing facility. If an insurer provides disability insurance, or if 2 or more insurers jointly provide disability insurance, to an insured under 2 or more policies, home care coverage is required under only one of the policies.

(d) Each visit by a person providing services under a home care plan or evaluating the need for or developing a plan shall be considered as one home care visit. The policy or self–insured health plan under sub. (1) (g) 2. and 3. may contain a limit on the number of home care visits, but not less than 40 visits in any 12–month period, for each person covered under the policy or self–insured health plan. Up to

4 consecutive hours in a 24–hour period of home health service shall be considered as one home care visit.

(e) Every disability insurance policy or self–insured health plan under sub. (1) (g) 2. and 3. which purports to provide coverage supplementing parts A and B of Title XVIII of the social security act shall make available and if requested by the insured provide coverage of supplemental home care visits beyond those provided by parts A and B, sufficient to produce an aggregate coverage of 365 home care visits per plan or policy year.

SECTION 53. 632.895 (3) of the statutes is amended to read:

632.895 **(3)** SKILLED NURSING CARE. Every disability insurance policy ~~filed after November 29, 1979, which~~ and every self–insured health plan under sub. (1) (g) 2. and 3. that provides coverage for hospital care shall provide coverage for at least 30 days for skilled nursing care to patients who enter a licensed skilled nursing care facility. A disability insurance policy or self–insured health plan, other than a medicare supplement policy or medicare replacement policy, may limit coverage under this subsection to patients who enter a licensed skilled nursing care facility within 24 hours after discharge from a general hospital. The daily rate payable under this subsection to a licensed skilled nursing care facility shall be no less than the maximum daily rate established for skilled nursing care in that facility by the department of health services for purposes of reimbursement under the medical assistance program under subch. IV of ch. 49. The coverage under this subsection shall apply only to skilled nursing care which is certified as medically necessary by the attending physician and is recertified as medically necessary every 7 days. If the disability insurance policy or self–insured health plan is other than a medicare supplement policy or medicare replacement policy, coverage under this subsection

shall apply only to the continued treatment for the same medical or surgical condition for which the insured had been treated at the hospital prior to entry into the skilled nursing care facility. Coverage under any disability insurance policy or self–insured health plan governed by this subsection may be subject to a deductible that applies to the hospital care coverage provided by the policy or plan. The coverage under this subsection shall not apply to care which is essentially domiciliary or custodial, or to care which is available to the insured without charge or under a governmental health care program, other than a program provided under ch. 49.

SECTION 54. 632.895 (4) (a) of the statutes is amended to read:

632.895 **(4)** (a) Every disability insurance policy ~~which~~ and every self–insured health plan under sub. (1) (g) 2. and 3. that provides hospital treatment coverage on an expense incurred basis shall provide coverage for hospital inpatient and outpatient kidney disease treatment, which may be limited to dialysis, transplantation and donor–related services, in an amount not less than $30,000 annually, as defined by the department of health services under par. (d).

SECTION 55. 632.895 (4) (c) of the statutes is amended to read:

632.895 **(4)** (c) Coverage under this subsection may not be subject to exclusions or limitations, including deductibles and coinsurance factors, which are not generally applicable to other conditions covered under the policy or plan.

SECTION 56. 632.895 (5) (a), (b), (c) and (d) of the statutes are amended to read:

632.895 **(5)** (a) Every disability insurance policy and every self–insured health plan under sub. (1) (g) 2. and 3. shall provide coverage for a newly born child of the insured from the moment of birth.

(b) Coverage for newly born children required under this subsection shall consider congenital defects and birth abnormalities as an injury or sickness under the policy or self–insured health plan under sub. (1) (g) 2. and 3. and shall cover functional repair or restoration of any body part when necessary to achieve normal body functioning, but shall not cover cosmetic surgery performed only to improve appearance.

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or self–insured health plan under sub. (1) (g) 2. and 3. may require that notification of the birth of a child and payment of the required premium or fees shall be furnished to the insurer within 60 days after the date of birth. The insurer may refuse to continue coverage beyond the 60–day period if such notification is not received, unless within one year after the birth of the child the insured makes all past–due payments and in addition pays interest on such payments at the rate of 5 1/2% per year.

(d) If payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy, self–insured health plan under sub. (1) (g) 2. and 3., or contract may request notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished.

SECTION 57. 632.895 (5m) of the statutes is amended to read:

632.895 **(5m)** COVERAGE OF GRANDCHILDREN. Every disability insurance policy ~~issued or renewed on or after May 7, 1986,~~ and every self–insured health plan under sub. (1) (g) 2. and 3. that provides coverage for any child of the insured shall provide the same coverage for all children of that child until that child is 18 years of age.

SECTION 58. 632.895 (6) and (7) of the statutes are amended to read:

632.895 **(6)** EQUIPMENT AND SUPPLIES FOR TREATMENT OF DIABETES. Every disability insurance policy and every self–insured health plan under sub. (1) (g) 2. and 3. which provides coverage of expenses incurred for treatment of diabetes shall provide coverage for expenses incurred by the installation and use of an insulin infusion pump, coverage for all other equipment and supplies, including insulin or any other prescription medication, used in the treatment of diabetes, and coverage of diabetic self–management education programs. Coverage required under this subsection shall be subject to the same exclusions, limitations, deductibles, and coinsurance provisions of the policy or self–insured health plan as other covered expenses, except that insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

(7) MATERNITY COVERAGE. Every group disability insurance policy ~~which~~ and every self–insured health plan under sub. (1) (g) 2. and 3. that provides maternity coverage shall provide maternity coverage for all persons covered under the policy. Coverage required under this subsection may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy or self–insured health plan.

SECTION 59. 632.895 (8) (b) 1. (intro.) and 2., (c), (d) and (e) (intro.) of the statutes are amended to read:

632.895 **(8)** (b) 1. (intro.) Except as provided in subd. 2. and par. (f), every disability insurance policy and every self–insured health plan under sub. (1) (g) 2. and 3. that provides coverage for a woman age 45 to 49 shall provide coverage for that woman of 2 examinations by low–dose mammography performed when the woman is age 45 to 49, if all of the following are satisfied:

2. A disability insurance policy or self–insured health plan under sub. (1) (g) 2. and 3. need not provide coverage under subd. 1. to the extent that the woman had obtained one or more examinations by low–dose mammography while between the ages of 45 and 49 and before obtaining coverage under the disability insurance policy or self–insured health plan.

(c) Except as provided in par. (f), every disability insurance policy and every self–insured health plan under sub. (1) (g) 2. and 3. that provides coverage for a woman age 50 or older shall provide coverage for that woman of an annual examination by low–dose mammography to screen for the presence of breast cancer, if the examination is performed at the direction of a licensed physician or a nurse practitioner or if par. (e) applies.

(d) Coverage is required under this subsection despite whether the woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c) and (e), coverage under this subsection may only be subject to exclusions and limitations, including deductibles, copayments and restrictions on excessive charges, that are applied to other radiological examinations covered under the disability insurance policy or self–insured health plan under sub. (1) (g) 2. and 3.

(e) (intro.) A disability insurance policy or self–insured health plan under sub. (1) (g) 2. and 3. shall cover an examination by low–dose mammography that is not performed at the direction of a licensed physician or a nurse practitioner but that is otherwise required to be covered under par. (b) or (c), if all of the following are satisfied:

SECTION 60. 632.895 (9) (b) (intro.) of the statutes is amended to read:

632.895 **(9)** (b) (intro.) Except as provided in par. (d), every disability insurance policy ~~that is issued or renewed on or after April 28, 1990,~~ and every self–insured

health plan under sub. (1) (g) 2. and 3. that provides coverage of prescription medication shall provide coverage for each drug that satisfies all of the following:

SECTION 61. 632.895 (9) (c) of the statutes is amended to read:

632.895 **(9)** (c) Coverage of a drug under par. (b) may be subject to any copayments and deductibles that the disability insurance policy or self–insured health plan under sub. (1) (g) 2. and 3. applies generally to other prescription medication covered by the disability insurance policy or self–insured health plan.

SECTION 62. 632.895 (10) (a) of the statutes is amended to read:

632.895 **(10)** (a) Except as provided in par. (b), every disability insurance policy and every ~~health care benefits plan provided on a self–insured basis by a county board under s. 59.52 (11), by a city or village under s. 66.0137 (4), by a political subdivision under s. 66.0137 (4m), by a town under s. 60.23 (25), or by a school district under s. 120.13 (2)~~ self–insured health plan under sub. (1) (g) 2. and 3. shall provide coverage for blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health services under s. 254.158.

SECTION 63. 632.895 (11) (a) (intro.) and (d) of the statutes are amended to read:

632.895 **(11)** (a) (intro.) Except as provided in par. (e), every disability insurance policy, and every self–insured health plan ~~of the state or a county, city, village, town or school district~~, that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle or tissue shall provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:

(d) Notwithstanding par. (c) 1., an insurer or a self–insured health plan ~~of the state or a county, city, village, town or school district~~ may require that an insured obtain prior authorization for any medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders.

SECTION 64. 632.895 (12) (b) (intro.) of the statutes is amended to read:

632.895 **(12)** (b) (intro.) Except as provided in par. (d), every disability insurance policy~~,~~ and every self–insured health plan ~~of the state or a county, city, village, town or school district,~~ shall cover hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgery center, if any of the following applies:

SECTION 65. 632.895 (12) (c) of the statutes is amended to read:

632.895 **(12)** (c) The coverage required under this subsection may be subject to any limitations, exclusions or cost–sharing provisions that apply generally under the disability insurance policy or self–insured health plan.

SECTION 66. 632.895 (13) (a) of the statutes is amended to read:

632.895 **(13)** (a) Every disability insurance policy, and every self–insured health plan ~~of the state or a county, city, village, town or school district~~, that provides coverage of the surgical procedure known as a mastectomy shall provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

SECTION 67. 632.895 (14) (b) of the statutes is amended to read:

632.895 **(14)** (b) Except as provided in par. (d), every disability insurance policy, and every self–insured health plan ~~of the state or a county, city, town, village or school district~~, that provides coverage for a dependent of the insured shall provide coverage

of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured.

SECTION 68. 632.895 (15) (a) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

632.895 **(15)** (a) Subject to pars. (b) and (c), every disability insurance policy~~,~~ and every self–insured health plan ~~of the state or a county, city, town, village, or school district,~~ that provides coverage for a person as a dependent of the insured because the person is a full–time student, including the coverage under s. 632.885 (2) (b), shall continue to provide dependent coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full–time student.

SECTION 69. 632.895 (16) (a) 4. of the statutes, as created by 2009 Wisconsin Act 14, is repealed.

SECTION 70. 632.895 (16) (c) 2. of the statutes, as created by 2009 Wisconsin Act 14, is amended to read:

632.895 **(16)** (c) 2. A disability insurance policy, or a self–insured health plan ~~of the state or a county, city, town, village, or school district~~, that provides only limited–scope dental or vision benefits.

SECTION 71. 632.895 (17) (b) (intro.) of the statutes, as created by 2009 Wisconsin Act 28, is amended to read:

632.895 **(17)** (b) (intro.) Every disability insurance policy~~,~~ and every self–insured health plan ~~of the state or of a county, city, town, village, or school district,~~ that provides coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices shall provide coverage for all of the following:

SECTION 72. 632.895 (17) (d) 2. of the statutes, as created by 2009 Wisconsin Act 28, is amended to read:

632.895 **(17)** (d) 2. A disability insurance policy~~,~~ or a self–insured health plan ~~of the state or a county, city, town, village, or school district,~~ that provides only limited–scope dental or vision benefits.

SECTION 73. 632.896 (1) (bg) of the statutes is created to read:

632.896 **(1)** (bg) "Insured" includes a person who participates in a self–insured health plan.

SECTION 74. 632.896 (1) (bk) of the statutes is created to read:

632.896 **(1)** (bk) "Insurer" includes a city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 75. 632.896 (1) (d) of the statutes is created to read:

632.896 **(1)** (d) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c) 2. and 3.

SECTION 76. 632.896 (2) of the statutes is amended to read:

632.896 **(2)** ADOPTED OR PLACED FOR ADOPTION. Every disability insurance policy ~~that is issued or renewed on or after March 1, 1991,~~ and every self–insured health plan, that provides coverage for dependent children of the insured, as defined in the disability insurance policy or self–insured health plan, shall cover adopted children of the insured and children placed for adoption with the insured, on the same terms and conditions, including exclusions, limitations, deductibles and copayments, as other dependent children, except as provided in subs. (3) to (6).

SECTION 77. 632.896 (3) (a) 2. of the statutes is amended to read:

632.896 **(3)** (a) 2. Subdivision 1. does not require coverage to begin before coverage is available under the disability insurance policy or self–insured health plan for other dependent children.

SECTION 78. 632.896 (4) of the statutes is amended to read:

632.896 **(4)** PREEXISTING CONDITIONS. Notwithstanding ss. 632.746 and 632.76 (2) (a), a disability insurance policy or self–insured health plan, that is subject to sub. (2) and that is in effect when a court makes a final order granting adoption or when the child is placed for adoption may not exclude or limit coverage of a disease or physical condition of the child on the ground that the disease or physical condition existed before coverage is required to begin under sub. (3).

SECTION 79. 632.896 (6) of the statutes is amended to read:

632.896 **(6)** NOTICE TO INSURER. The disability insurance policy or self–insured health plan may require the insured to notify the insurer that a child is adopted or placed for adoption and to pay the insurer any premium or fees required to provide coverage for the child, within 60 days after coverage is required to begin under sub. (3). If the insured fails to give notice or make payment within 60 days as required by the disability insurance policy or self–insured health plan in accordance with this subsection, the disability insurance policy or self–insured health plan shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage.

SECTION 80. 635.02 (3k) of the statutes is amended to read:

635.02 **(3k)** "Group health benefit plan" has the meaning given in s. 632.745 (9) (a) and (b).

SECTION 81. 645.02 (8) of the statutes is created to read:

645.02 **(8)** A city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 82. 646.01 (1) (a) 3. of the statutes is created to read:

646.01 **(1)** (a) 3. A city, town, village, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 83. 646.01 (1) (b) 9. of the statutes is amended to read:

646.01 **(1)** (b) 9. ~~Any~~ Except for a self–insured health plan of a city, town, village, county, or school district, any self–funded, self–insured, or partially or wholly uninsured plan of an employer or other person to provide life insurance, annuity, or disability benefits to its employees or members to the extent that the plan is self–funded, self–insured, or uninsured.

SECTION 84. 646.03 (2q) of the statutes is created to read:

646.03 **(2q)** "Insurer" includes a city, village, town, county, or school district that provides a self–insured health plan, with respect to the self–insured health plan.

SECTION 85. Initial applicability.

(1) This act first applies to the following:

(a) Except as provided in paragraph (b), self–insured governmental health plans provided by that are established, extended, modified, or renewed on the effective date of this paragraph.

(b) Self–insured governmental health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

SECTION 86. Effective date.

(1) This act takes effect on the first day of the 7th month beginning after publication.

(END)