



## 2015 ASSEMBLY BILL 197

May 5, 2015 – Introduced by Representatives CZAJA, BERNIER, EDMING, KNODL, KRUG, T. LARSON, MURSAU, ROHRKASTE and THIESFELDT, cosponsored by Senators VUKMIR, COWLES and NASS. Referred to Committee on Insurance.

1     **AN ACT** *to amend* 185.983 (1) (intro.); and *to create* 609.72 and 632.799 of the  
2             statutes; **relating to:** information to be provided by insurers about health care  
3             plans offered on the American health benefit exchange.

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### *Analysis by the Legislative Reference Bureau*

Under the federal Patient Protection and Affordable Care Act (ACA), which was enacted on March 23, 2010, each state must establish an American health benefit exchange (exchange) through which individuals and certain businesses may purchase health insurance. The federal government will establish and operate an exchange in a state that does not establish its own. Health insurance offered through the exchange must meet certain federal requirements, including offering the essential health benefits package that is established by the federal Department of Health and Human Services. Such a health benefit plan is called a qualified health plan (plan) under the ACA.

This bill requires a insurer that offers plans through an exchange that is operating in this state to provide access on the insurer's Internet site to information, in a clear and understandable form, that will enable consumers shopping for health insurance on the exchange to determine all of the following about the insurer's plans offered through the exchange: exclusions from coverage and restrictions on use or quantity of covered services or items; any service or item with a cost-sharing requirement that depends on the cost of the service or item; whether a specific prescription drug is covered and any clinical prerequisites or authorization requirements for coverage of a prescription drug; whether specific types of specialists

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are included, and whether a specific named specialist is included, in the plan's network; the process for appealing a denial of coverage of a service or item; and how the out-of-pocket costs of medications will or will not be applied towards the deductible under the plan.

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

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

2           185.983 (1) (intro.) Every voluntary nonprofit health care plan operated by a  
3 cooperative association organized under s. 185.981 shall be exempt from chs. 600 to  
4 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44,  
5 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93,  
6 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.799,  
7 632.85, 632.853, 632.855, 632.867, 632.87 (2), (2m), (3), (4), (5), and (6), 632.885,  
8 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630,  
9 635, 645, and 646, but the sponsoring association shall:

10           **SECTION 2.** 609.72 of the statutes is created to read:

11           **609.72 Required plan information.** Defined network plans are subject to  
12 s. 632.799.

13           **SECTION 3.** 632.799 of the statutes is created to read:

14           **632.799 Information about plans offered through an American health**  
15 **benefit exchange. (1) DEFINITIONS.** In this section:

16           (a) “Exchange” means an American health benefit exchange, as described in 42  
17 USC 18031, that is operating in this state.

18           (b) “Qualified health plan” has the meaning given in 42 USC 18021 (a).

19           **(2) INFORMATION THAT MUST BE PROVIDED.** (a) To enable consumers to compare  
20 coverage among qualified health plans offered through an exchange, an insurer that

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1 offers a qualified health plan through an exchange shall, in addition to any other  
2 information that is required under federal law, provide access to information about  
3 the qualified health plan, in a clear and understandable form, such that consumers  
4 are able to determine all of the following with respect to the qualified health plan:

5 1. Any exclusions from coverage and any restrictions on use or quantity of  
6 covered services and items in each category of benefits, including prescription drugs  
7 and drugs administered in a physician's office or in a clinic.

8 2. Any service or item with a cost-sharing requirement, including a  
9 prescription drug, for which the cost sharing required depends on the cost of the  
10 service or item.

11 3. Whether a specific prescription drug is covered by the qualified health plan,  
12 whether a specific prescription drug is covered when furnished by a physician or  
13 clinic, and any clinical prerequisites or authorization requirements for coverage of  
14 a prescription drug.

15 4. Whether specific types of specialists are included in the qualified health  
16 plan's network and whether a specific named physician is in the qualified health  
17 plan's network.

18 5. The process for an insured to appeal a decision of the qualified health plan  
19 denying coverage of a service or item prescribed or ordered by a treating physician.

20 6. How the cost of medications will be included in or excluded from the  
21 deductible under the qualified health plan, including a description of out-of-pocket  
22 costs for a medication that do not apply towards the deductible.

23 (b) The information required under par. (a) shall be made available on the  
24 insurer's Internet site.

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**SECTION 3**

1 (c) Nothing in this section requires an insurer to provide information that  
2 duplicates information that the insurer already provides.

3 (END)