2019 DRAFTING REQUEST

Assembly Amendment (AA-AB1)

For: **Mike Rohrkaste (608) 266-5719**

Drafter: **tdodge**

By: **Matt**

Secondary Drafters:

Date: **1/9/2019**

May Contact:

Same as LRB:

Submit via email: **YES**
Requester's email: **Rep.Rohrkaste@legis.wisconsin.gov**
Carbon copy (CC) to: **tamara.dodge@legis.wisconsin.gov**

Pre Topic:

No specific pre topic given

Topic:

Exceptions to guaranteed issue for service area and financial reserves; preexisting condition exclusion

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Submitted	Jacketed	Required
/?	tdodge 1/10/2019	csicilia 1/11/2019			
/P1	tdodge 1/11/2019	csicilia 1/14/2019	mbarman 1/11/2019		
/P2	tdodge 1/16/2019	csicilia 1/16/2019	dwalker 1/14/2019		
/1			mbarman 1/16/2019	mbarman 1/16/2019	

FE Sent For:

<END>

1/9

Per Matt from Rep. Rohrkaste's office

Amend LRB-1169 (AB 1)

1) Include exceptions to guaranteed issue found in ACA @ 42 USC 300gg-1 (c) & (d)
outside service area, capacity of provider network
financial reserves

2) Include definition of preexisting condition
exclusion from ACA (42 USC 300gg-3 (b)(1)(A))

State of Wisconsin
2019 - 2020 LEGISLATURE

LRBa0015/?
TJD:...

In: 1/10

Due Fri 1/11 morning ASAP (H)

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

ASSEMBLY AMENDMENT ,

TO ASSEMBLY BILL 1

D-note

At the locations indicated, amend the bill as follows:

1. Page 3, line 24: after that line insert:

"(ag) "Defined network plan" has the meaning given in s. 609.01 (1b).".

2. Page 3, line 25: delete "(a)" and substitute "(am)".

3. Page 3, line 25: after that line insert:

"(ar) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date of enrollment for coverage.".

4. Page 4, line 3: delete "Every" and substitute "Except as provided in par. (b) or (c), every".

5. Page 4, line 8: after that line insert:

"(b) A health benefit plan that is a defined network plan may do any of the following:

1. Limit the employers that may apply for group health benefit plan coverage to those employers whose employees live, work, or reside in the service area for the defined network plan.

2. Deny coverage to employers and individuals in the service area of the defined network plan if the defined network plan has demonstrated to the commissioner all of the following:

a. The defined network plan does not have the capacity to deliver services adequately to enrollees of any additional groups or individuals because of its obligations to existing defined network plan enrollees.

additional

b. The defined network plan is denying coverage uniformly to all employers and individuals without regard to the claims experience or health status-related factor, as described under s. 632.748 (1) (a) 1. to 8., of the individuals, employers, employees, or dependents of individuals or employees.

(c) A group or individual health benefit plan may deny coverage if the plan has demonstrated to the commissioner all of the following:

1. The issuer of the health benefit plan does not have the financial reserves necessary to underwrite additional coverage.

2. The defined network plan is denying coverage uniformly to all employers and individuals without regard to the claims experience or health status-related factor, as described under s. 632.748 (1) (a) 1. to 8., of the individuals, employers, employees, or dependents of individuals or employees.

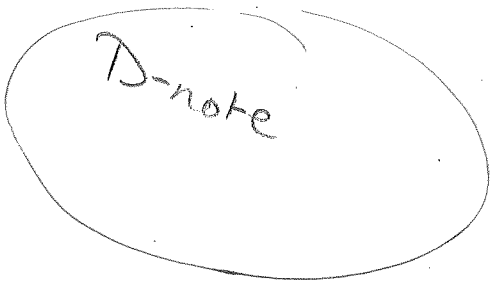
group or individual health benefit ~~plan~~

(d) A defined network plan that denies coverage under par. (b) 2. may not offer coverage within the service area of the defined network plan within 180 days after the date coverage is denied under par. (b) 2. An issuer of a health benefit plan that denies coverage under par. (c) may not offer coverage under a group or individual health benefit plan in the state within 180 days after the date coverage is denied under par. (c) or until the date the issuer of the health benefit plan demonstrates to the commissioner that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.".

6. Page 5, line 3: delete "(a) A" and substitute "An individual or".

7. Page 5, line 6: delete lines 6 to 11.

(END)



DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBa0015/P1dn
TJD:...

Date

Representative Rohrkaste:

This amendment to 2019 Assembly Bill 1 does the following two things: it incorporates some exceptions to the guaranteed issue requirements that are present in the Affordable Care Act under 42 USC 300gg-1 (c) and (d) and it conforms the prohibition against a preexisting condition exclusion more closely to the Affordable Care Act under 42 USC 300gg-3.

The Affordable Care Act and Assembly Bill 1 require health benefit plans to accept every individual, if an individual health benefit plan, and every employer, if a group health benefit plan, that apply for coverage. The Affordable Care Act allows health benefit plans that provide services through a set network of providers to decline to cover employers whose employees are outside of the service area of the provider network and to decline to cover employers or individuals if the provider network does not have the capacity to accept additional insureds, as long as the plan declines individuals or employers without regard to their claims experience or health status. The Wisconsin statutes refer to plans that have set networks of providers, such as health maintenance organizations, as "defined network plans." The Affordable Care Act also allows a health benefit plan to decline to cover individuals or groups if the plan does not have the necessary financial reserves, as long as the plan declines the additional insureds without regard to their claims experience or health status. The Affordable Care Act then imposes on plans that have declined coverage based on lack of provider capacity or lack of financial reserves a time restriction on taking additional insureds. This amendment incorporates these exemptions from the Affordable Care Act into Assembly Bill 1.

This amendment aligns the language of the prohibition in Assembly Bill 1 against plans excluding coverage of a preexisting condition more closely with the Affordable Care Act under 42 USC 300gg-3. In addition to applying the same language to individuals and group plans, this amendment includes the definition of "preexisting condition exclusion" from the Affordable Care Act.

Should you have any questions or want any changes to the amendment, please contact me.

Tamara J. Dodge
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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBa0015/P1dn
TJD:cjs

January 11, 2019

Representative Rohrkaste:

This amendment to 2019 Assembly Bill 1 does the following two things: it incorporates some exceptions to the guaranteed issue requirements that are present in the Affordable Care Act under 42 USC 300gg-1 (c) and (d), and it conforms the prohibition against a preexisting condition exclusion more closely to the Affordable Care Act under 42 USC 300gg-3.

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1/11

Redraft a0015 per Matt from Rep Rohrkaste's office

Align AB1 with treatment of grandfathered plans under ACA (42 USC 18011)

Individual & group – not required to guarantee issue

Individual – exempt from preexisting condition exclusion prohibition

State of Wisconsin
2019 - 2020 LEGISLATURE

LRBa0015/P1 P2
TJD:cjs

In: 1/11 Due ASAP Mon 1/14

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

ASSEMBLY AMENDMENT ,

TO ASSEMBLY BILL 1

D-note

At the locations indicated, amend the bill as follows:

1. Page 3, line 24: after that line insert:

"(ag) "Defined network plan" has the meaning given in s. 609.01 (1b).".

2. Page 3, line 25: delete "(a)" and substitute "(am)".

3. Page 3, line 25: after that line insert:

"(ar) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date of enrollment for coverage.".

4. Page 4, line 3: delete "Every" and substitute "Except as provided in par. (b) or (c), every".

5. Page 4, line 8: after that line insert:

"(b) A health benefit plan that is a defined network plan may do any of the following:

1. Limit the employers that may apply for group health benefit plan coverage to those employers whose employees live, work, or reside in the service area for the defined network plan.

2. Deny coverage to employers and individuals in the service area of the defined network plan if the defined network plan has demonstrated to the commissioner all of the following:

a. The defined network plan does not have the capacity to deliver services adequately to enrollees of any additional groups or additional individuals because of its obligations to existing defined network plan enrollees.

b. The defined network plan is denying coverage uniformly to all employers and individuals without regard to the claims experience or health status-related factor, as described under s. 632.748 (1) (a) 1. to 8., of the individuals, employers, employees, or dependents of individuals or employees.

(c) A group or individual health benefit plan may deny coverage if the plan has demonstrated to the commissioner all of the following:

1. The issuer of the health benefit plan does not have the financial reserves necessary to underwrite additional coverage.

2. The group or individual health benefit plan is denying coverage uniformly to all employers and individuals without regard to the claims experience or health status-related factor, as described under s. 632.748 (1) (a) 1. to 8., of the individuals, employers, employees, or dependents of individuals or employees.

(d) A defined network plan that denies coverage under par. (b) 2. may not offer coverage within the service area of the defined network plan within 180 days after the date coverage is denied under par. (b) 2. An issuer of a health benefit plan that denies coverage under par. (c) may not offer coverage under a group or individual health benefit plan in this state within 180 days after the date coverage is denied under par. (c) or until the date the issuer of the health benefit plan demonstrates to the commissioner that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.".

Insert 3-9

6. Page 5, line 3: delete "(a) A" and substitute "An individual or".

7. Page 5, line 6: delete lines 6 to 11.

Insert 3-11

(END)

D-note

INSERT 3-9

1. Page 4, line 9: delete "(a)".

2. Page 4, line 12: delete "1." and substitute "(a)".

3. Page 4, line 13: delete "2." and substitute "(b)".

4. Page 4, line 14: delete "3." and substitute "(c)".

5. Page 4, line 17: delete "4." and substitute "(d)".

6. Page 4, line 18: delete lines 18 to 20.

END INSERT 3-9

INSERT 3-11

7. Page 5, line 12: after "APPLICABILITY." insert "(a) A health benefit plan that is considered a grandfathered health plan under 42 USC 18011 as of January 1, 2019, or has transitional status as of January 1, 2019, granted by the federal department of health and human services and the commissioner is not required to comply with sub. (2) or (3). An individual health benefit plan that is considered a grandfathered health plan under 42 USC 18011 as of January 1, 2019, or has transitional status as of January 1, 2019, granted by the federal department of health and human services and the commissioner is not required to comply with sub. (5).

(b)".

END INSERT 3-11

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBa0015/P2dn
TJD:...

Date

Insert A

The Affordable Care Act exempts plans in existence on March 23, 2010, known as grandfathered plans, from provisions of the Affordable Care Act including the limitation on premium rate variation, the requirement to guarantee issue, and for individual grandfathered plans, the prohibition against imposing a preexisting condition exclusion. Under the Affordable Care Act, to remain a grandfathered plan, the plan may not enroll new individuals or groups except for family members of individuals already enrolled. Similarly, transitional plans are plans exempt from certain provisions of the Affordable Care Act in which individuals and groups enrolled between March 24, 2010, and the end of 2013. The Affordable Care Act exempts grandfathered plans from the limitation on premium rate variation and Assembly Bill 1 includes this exemption for grandfathered and transitional plans. The amendment adds an exemption for all grandfathered and transitional plans from the requirement to guarantee issue and exempts individual grandfathered and transitional plans from the prohibition against imposing a preexisting condition exclusion.

Insert B

Inserts for D-note

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBa0015/P1dn
TJD:cjs

January 11, 2019

Insert A

Representative Rohrkaste:

This amendment to 2019 Assembly Bill 1 does the following two things: it incorporates some exceptions to the guaranteed issue requirements that are present in the Affordable Care Act under 42 USC 300gg-1 (c) and (d), and it conforms the prohibition against a preexisting condition exclusion more closely to the Affordable Care Act under 42 USC 300gg-3.

and the exemptions for grandfathered plans

The Affordable Care Act and Assembly Bill 1 require health benefit plans to accept every individual, if an individual health benefit plan, and every employer, if a group health benefit plan, that apply for coverage. The Affordable Care Act allows health benefit plans that provide services through a set network of providers to decline to cover employers whose employees are outside of the service area of the provider network and to decline to cover employers or individuals if the provider network does not have the capacity to accept additional insureds, as long as the plan declines individuals or employers without regard to their claims experience or health status. The Wisconsin statutes refer to plans that have set networks of providers, such as health maintenance organizations, as "defined network plans." The Affordable Care Act also allows a health benefit plan to decline to cover individuals or groups if the plan does not have the necessary financial reserves, as long as the plan declines the additional insureds without regard to their claims experience or health status. The Affordable Care Act then imposes on plans that have declined coverage based on lack of provider capacity or lack of financial reserves a time restriction on taking additional insureds. This amendment incorporates these exemptions from the Affordable Care Act into Assembly Bill 1.

This amendment aligns the language of the prohibition in Assembly Bill 1 against plans excluding coverage of a preexisting condition more closely with the Affordable Care Act under 42 USC 300gg-3. In addition to applying the same language to individuals and group plans, this amendment includes the definition of "preexisting condition exclusion" from the Affordable Care Act.

End Insert A

Should you have any questions or want any changes to the amendment, please contact me.

Insert B

Tamara J. Dodge
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End Insert B

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBa0015/P2dn
TJD:cjs

January 14, 2019

Representative Rohrkaste:

This amendment to 2019 Assembly Bill 1 does the following things: it incorporates some exceptions to the guaranteed issue requirements that are present in the Affordable Care Act under 42 USC 300gg-1 (c) and (d), and it conforms the prohibition against a preexisting condition exclusion and the exemptions for grandfathered plans more closely to the Affordable Care Act.

The Affordable Care Act and Assembly Bill 1 require health benefit plans to accept every individual, if an individual health benefit plan, and every employer, if a group health benefit plan, that apply for coverage. The Affordable Care Act allows health benefit plans that provide services through a set network of providers to decline to cover employers whose employees are outside of the service area of the provider network and to decline to cover employers or individuals if the provider network does not have the capacity to accept additional insureds, as long as the plan declines individuals or employers without regard to their claims experience or health status. The Wisconsin statutes refer to plans that have set networks of providers, such as health maintenance organizations, as "defined network plans." The Affordable Care Act also allows a health benefit plan to decline to cover individuals or groups if the plan does not have the necessary financial reserves, as long as the plan declines the additional insureds without regard to their claims experience or health status. The Affordable Care Act then imposes on plans that have declined coverage based on lack of provider capacity or lack of financial reserves a time restriction on taking additional insureds. This amendment incorporates these exemptions from the Affordable Care Act into Assembly Bill 1.

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The Affordable Care Act exempts plans in existence on March 23, 2010, known as grandfathered plans, from provisions of the Affordable Care Act, including the limitation on premium rate variation, the requirement to guarantee issue, and for individual plans, the prohibition against imposing a preexisting condition exclusion.

Under the Affordable Care Act, to remain a grandfathered plan, the plan may not enroll new individuals or groups except for family members of individuals already enrolled. Similarly, transitional plans are plans exempt from certain provisions of the Affordable Care Act in which individuals and groups enrolled between March 24, 2010, and the end of 2013.

The Affordable Care Act exempts grandfathered plans from the limitation on premium rate variation, and Assembly Bill 1 includes this exemption for grandfathered and transitional plans. The amendment adds an exemption for all grandfathered and transitional plans from the requirement to guarantee issue and exempts grandfathered and transitional individual plans from the prohibition against imposing a preexisting condition exclusion.

Should you have any questions or want any changes to the amendment, please contact me.

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State of Wisconsin
2019 - 2020 LEGISLATURE

LRBa0015/P2
TJD:cjs

Due A&AP

In 1/16

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

ASSEMBLY AMENDMENT ,

TO ASSEMBLY BILL 1

Dnote

At the locations indicated, amend the bill as follows:

1. Page 3, line 24: after that line insert:

"(ag) "Defined network plan" has the meaning given in s. 609.01 (1b).".

2. Page 3, line 25: delete "(a)" and substitute "(am)".

3. Page 3, line 25: after that line insert:

"(ar) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date of enrollment for coverage.". (a)

4. Page 4, line 3: delete "Every" and substitute "Except as provided in par. (b) or (c), every".

5. Page 4, line 8: after that line insert:

"(b) A health benefit plan that is a defined network plan may do any of the following:

1. Limit the employers that may apply for group health benefit plan coverage to those employers whose employees live, work, or reside in the service area for the defined network plan.

2. Deny coverage to employers and individuals in the service area of the defined network plan if the defined network plan has demonstrated to the commissioner all of the following:

a. The defined network plan does not have the capacity to deliver services adequately to enrollees of any additional groups or additional individuals because of its obligations to existing defined network plan enrollees.

b. The defined network plan is denying coverage uniformly to all employers and individuals without regard to the claims experience or health status-related factor, as described under s. 632.748 (1) (a) 1. to 8., of the individuals, employers, employees, or dependents of individuals or employees.

(c) A group or individual health benefit plan may deny coverage if the plan has demonstrated to the commissioner all of the following:

1. The issuer of the health benefit plan does not have the financial reserves necessary to underwrite additional coverage.

2. The group or individual health benefit plan is denying coverage uniformly to all employers and individuals without regard to the claims experience or health status-related factor, as described under s. 632.748 (1) (a) 1. to 8., of the individuals, employers, employees, or dependents of individuals or employees.

(d) A defined network plan that denies coverage under par. (b) 2. may not offer coverage within the service area of the defined network plan within 180 days after the date coverage is denied under par. (b) 2. An issuer of a health benefit plan that denies coverage under par. (c) may not offer coverage under a group or individual health benefit plan in this state within 180 days after the date coverage is denied under par. (c) or until the date the issuer of the health benefit plan demonstrates to the commissioner that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.".

6. Page 4, line 9: delete "(a)".

7. Page 4, line 12: delete "1." and substitute "(a)".

8. Page 4, line 13: delete "2." and substitute "(b)".

9. Page 4, line 14: delete "3." and substitute "(c)".

10. Page 4, line 17: delete "4." and substitute "(d)".

11. Page 4, line 18: delete lines 18 to 20.

12. Page 5, line 3: delete "(a) A" and substitute "An individual or".

13. Page 5, line 6: delete lines 6 to 11.

14. Page 5, line 12: after "APPLICABILITY." insert "(a) A health benefit plan that is considered a grandfathered health plan under 42 USC 18011 as of January 1, 2019, or has transitional status as of January 1, 2019, granted by the federal department of health and human services and the commissioner is not required to comply with sub. (2) or (3). An individual health benefit plan that is considered a grandfathered health plan under 42 USC 18011 as of January 1, 2019, or has transitional status as

of January 1, 2019, granted by the federal department of health and human services and the commissioner is not required to comply with sub. (5).

(b)".

(END)

D-note

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBa0015/P2dn
TJD:cjs

January 14, 2019 DATE

Representative Rohrkaste:

This amendment to 2019 Assembly Bill 1 does the following things: it incorporates some exceptions to the guaranteed issue requirements that are present in the Affordable Care Act under 42 USC 300gg-1 (c) and (d), and it conforms the prohibition against a preexisting condition exclusion and the exemptions for grandfathered plans more closely to the Affordable Care Act.

The Affordable Care Act and Assembly Bill 1 require health benefit plans to accept every individual, if an individual health benefit plan, and every employer, if a group health benefit plan, that apply for coverage. The Affordable Care Act allows health benefit plans that provide services through a set network of providers to decline to cover employers whose employees are outside of the service area of the provider network and to decline to cover employers or individuals if the provider network does not have the capacity to accept additional insureds, as long as the plan declines individuals or employers without regard to their claims experience or health status. The Wisconsin statutes refer to plans that have set networks of providers, such as health maintenance organizations, as "defined network plans." The Affordable Care Act also allows a health benefit plan to decline to cover individuals or groups if the plan does not have the necessary financial reserves, as long as the plan declines the additional insureds without regard to their claims experience or health status. The Affordable Care Act then imposes on plans that have declined coverage based on lack of provider capacity or lack of financial reserves a time restriction on taking additional insureds. This amendment incorporates these exemptions from the Affordable Care Act into Assembly Bill 1.

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The Affordable Care Act exempts plans in existence on March 23, 2010, known as grandfathered plans, from provisions of the Affordable Care Act, including the limitation on premium rate variation, the requirement to guarantee issue, and for individual plans, the prohibition against imposing a preexisting condition exclusion.

Under the Affordable Care Act, to remain a grandfathered plan, the plan may not enroll new individuals or groups except for family members of individuals already enrolled. Similarly, transitional plans are plans exempt from certain provisions of the Affordable Care Act in which individuals and groups enrolled between March 24, 2010, and the end of 2013.

The Affordable Care Act exempts grandfathered plans from the limitation on premium rate variation, and Assembly Bill 1 includes this exemption for grandfathered and transitional plans. The amendment adds an exemption for all grandfathered and transitional plans from the requirement to guarantee issue and exempts grandfathered and transitional individual plans from the prohibition against imposing a preexisting condition exclusion.

Should you have any questions or want any changes to the amendment, please contact me.

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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBa0015/1dn
TJD:cjs

January 16, 2019

Representative Rohrkaste:

This amendment to 2019 Assembly Bill 1 does the following things: it incorporates some exceptions to the guaranteed issue requirements that are present in the Affordable Care Act under 42 USC 300gg-1 (c) and (d), and it conforms the prohibition against a preexisting condition exclusion and the exemptions for grandfathered plans more closely to the Affordable Care Act.

The Affordable Care Act and Assembly Bill 1 require health benefit plans to accept every individual, if an individual health benefit plan, and every employer, if a group health benefit plan, that apply for coverage. The Affordable Care Act allows health benefit plans that provide services through a set network of providers to decline to cover employers whose employees are outside of the service area of the provider network and to decline to cover employers or individuals if the provider network does not have the capacity to accept additional insureds, as long as the plan declines individuals or employers without regard to their claims experience or health status. The Wisconsin statutes refer to plans that have set networks of providers, such as health maintenance organizations, as "defined network plans." The Affordable Care Act also allows a health benefit plan to decline to cover individuals or groups if the plan does not have the necessary financial reserves, as long as the plan declines the additional insureds without regard to their claims experience or health status. The Affordable Care Act then imposes on plans that have declined coverage based on lack of provider capacity or lack of financial reserves a time restriction on taking additional insureds. This amendment incorporates these exemptions from the Affordable Care Act into Assembly Bill 1.

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The Affordable Care Act exempts plans in existence on March 23, 2010, known as grandfathered plans, from provisions of the Affordable Care Act, including the limitation on premium rate variation, the requirement to guarantee issue, and for individual plans, the prohibition against imposing a preexisting condition exclusion.

Under the Affordable Care Act, to remain a grandfathered plan, the plan may not enroll new individuals or groups except for family members of individuals already enrolled. Similarly, transitional plans are plans exempt from certain provisions of the Affordable Care Act in which individuals and groups enrolled between March 24, 2010, and the end of 2013.

The Affordable Care Act exempts grandfathered plans from the limitation on premium rate variation, and Assembly Bill 1 includes this exemption for grandfathered and transitional plans. The amendment adds an exemption for all grandfathered and transitional plans from the requirement to guarantee issue and exempts grandfathered and transitional individual plans from the prohibition against imposing a preexisting condition exclusion.

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