

**2019 DRAFTING REQUEST**

**Bill**

For: **Administration-Budget** Drafter: **tdodge**  
 By: **Ames** Secondary Drafters:  
 Date: **2/15/2019** May Contact:

Same as LRB:

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

**Pre Topic:**

DOA:.....Ames, BB0405 -

**Topic:**

Preexisting conditions coverage

**Instructions:**

See attached

**Drafting History:**

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Submitted</u>	<u>Jacketed</u>	<u>Required</u>
/?	tdodge 2/16/2019	csicilia 2/17/2019			
/P1			chanaman 2/17/2019		Insurance

FE Sent For: **<END>**

**Dodge, Tamara**

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**From:** Cathlene Hanaman <cathleneh@gmail.com>  
**Sent:** Friday, February 15, 2019 5:44 PM  
**To:** Dodge, Tamara; Lunder, Erika  
**Subject:** Fwd: Statutory Language Drafting Request - 2019-21

Sent from my iPhone

Begin forwarded message:

Biennial Budget: 2019-21

Topic: Preexisting Conditions Coverage

Tracking Code: BB0405

SBO Team: HSI

SBO Analyst: Ames, Kyle  
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Agency Acronym: 435

Agency Number: 435

Priority: Low

Intent:

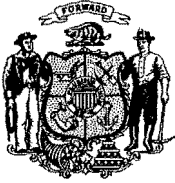
*— LRB-1438*  
Please provide language similar to the attached bill to provide insurance coverage for individuals with preexisting conditions.

Attachments: True

Please send completed drafts to [SBOStatlanguage@spmail.enterprise.wistate.us](mailto:SBOStatlanguage@spmail.enterprise.wistate.us)

In: 2/16

2091/P1



State of Wisconsin  
2019 - 2020 LEGISLATURE

LRB-1438/1

TJD:cjs&wlj

stays

2019 SENATE BILL 37

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February 15, 2019 - Introduced by Senators ERPENBACH, SCHACHTNER, BEWLEY, CARPENTER, HANSEN, JOHNSON, MILLER, RINGHAND, RISSER, SHILLING, SMITH, WIRCH and LARSON, cosponsored by Representatives RIEMER, BILLINGS, CONSIDINE, CROWLEY, HESSELBEIN, POPE, SINICKI, SPREITZER, SHANKLAND, SUBECK, C. TAYLOR and VRUWINK. Referred to Committee on Health and Human Services.

remove catalog

1 AN ACT to repeal 632.746 (1) (b), 632.746 (2) (c), (d) and (e), 632.746 (3) (a),  
2 632.746 (3) (d) 2. and 3., 632.746 (5) and 632.76 (2) (ac) 3.; to renumber 632.746  
3 (3) (d) 1.; to renumber and amend 632.746 (1) (a); to amend 40.51 (8), 40.51  
4 (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 625.12 (1) (a), 625.12 (1) (e),  
5 625.12 (2), 625.15 (1), 628.34 (3) (a), 632.746 (2) (a), 632.746 (8) (a) (intro.),  
6 632.748 (2), 632.76 (2) (a) and (ac) 1. and 2., 632.795 (4) (a), 632.895 (8) (d),  
7 632.895 (14) (a) 1. i. and j., 632.895 (14) (b), 632.895 (14) (c), 632.895 (14) (d) 3.,  
8 632.895 (16m) (b), 632.895 (17) (b) 2., 632.895 (17) (c) and 632.897 (11) (a); and  
9 to create 609.713, 609.847, 632.728, 632.895 (13m), 632.895 (14) (a) 1. k. to o.  
10 and 632.895 (14m) of the statutes; relating to: coverage of preventive services,  
11 essential health benefits, and individuals with preexisting conditions; rating;  
12 and benefit limits under health plans.

be the budget

Analysis by the Legislative Reference Bureau

This bill requires certain health plans to guarantee access to coverage; prohibits plans from imposing preexisting condition exclusions; prohibits plans from

INSURANCE <head>

# Coverage of individuals with preexisting conditions, essential health benefits, and preventive services

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setting premiums or cost-sharing amounts based on a health status-related factors; prohibits plans from setting lifetime or annual limits on benefits; requires plans to cover certain essential health benefits; and requires coverage of certain preventive services by plans without a cost-sharing contribution by an enrollee.

***Coverage of individuals with preexisting conditions; rating; benefit limits.***

This bill requires every individual health insurance policy, known in the bill as a health benefit plan, to accept every individual who, and every group health insurance policy to accept every employer that, applies for coverage, regardless of sexual orientation, gender identity, or whether an employee or individual has a preexisting condition. The bill allows health benefit plans to restrict enrollment in coverage to open or special enrollment periods and requires the commissioner of the Office of the Commissioner of Insurance to establish a statewide open enrollment period of no shorter than 30 days for every individual health benefit plan. The bill prohibits a group health insurance policy, including a self-insured governmental health plan, from imposing a preexisting condition exclusion. The bill also prohibits an individual health 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.

A health benefit plan offered on the individual or small employer market or a self-insured governmental health plan may not vary premium rates for a specific plan except on the basis of whether the plan covers an individual or family, area in the state, age, and tobacco use as specified in the bill. An individual health benefit plan or self-insured health plan is prohibited under the bill from establishing rules for the eligibility of any individual to enroll based on health-status related factors, which are specified in the bill. A self-insured health plan or an insurer offering an individual health benefit plan is also prohibited from requiring an enrollee to pay a greater premium, contribution, deductible, copayment, or coinsurance amount than is required of a similarly situated enrollee based on a health-status related factor. Current state law prohibits group health benefit plans from establishing rules of eligibility or requiring greater premium or contribution amounts based on a health-status related factor. The bill adds to these current law requirements for group health benefit plans that the plan may not require a greater deductible, copayment, or coinsurance amount based on a health-status related factor.

Under the bill, an individual or group health benefit plan or a self-insured governmental health plan may not establish lifetime or annual limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the plan.

The requirements and prohibitions in this bill related to coverage of individuals with preexisting conditions and prohibition of lifetime and annual benefit limits also apply to short-term, limited-duration health insurance policies.

***Coverage of essential health benefits and preventive services***

This bill requires certain health insurance policies, known in the bill as disability insurance policies, and governmental self-insured health plans to cover essential health benefits that will be specified by the commissioner of insurance by rule. The bill specifies a list of requirements that the commissioner must follow when establishing the essential health benefits including certain limitations on cost

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sharing and the following general categories of benefits, items, or services in which the commissioner must require coverage: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services. If an essential health benefit specified by the commissioner is also subject to its own mandated coverage requirement, the bill requires the disability insurance policy or self-insured health plan to provide coverage under whichever requirement provides the insured or plan participant with more comprehensive coverage.

This bill requires health insurance policies and governmental self-insured health plans to cover certain preventive services and to provide coverage of those preventive services without subjecting that coverage to deductibles, copayments, or coinsurance. The preventive services for which coverage is required are specified in the bill. The bill also specifies certain instances when cost-sharing amounts may be charged for an office visit associated with a preventive service.

This proposal may contain a health insurance mandate requiring a social and financial impact report under s. 601.423, stats.

Keep

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

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

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

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

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

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

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1           66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or  
2 a village provides health care benefits under its home rule power, or if a town  
3 provides health care benefits, to its officers and employees on a self-insured basis,  
4 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),  
5 632.728, 632.746 (1) and (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853,  
6 632.855, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) (8) to (17), 632.896,  
7 and 767.513 (4).

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

9           120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.  
10 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.746 (1) and (10) (a) 2. and (b)  
11 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.885,  
12 632.89, 632.895 (9) (8) to (17), 632.896, and 767.513 (4).

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

14           185.983 (1) (intro.) Every voluntary nonprofit health care plan operated by a  
15 cooperative association organized under s. 185.981 shall be exempt from chs. 600 to  
16 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44,  
17 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93,  
18 631.95, 632.72 (2), 632.728, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798,  
19 632.85, 632.853, 632.855, 632.867, 632.87 (2) to (6), 632.885, 632.89, 632.895 (5) and  
20 (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but  
21 the sponsoring association shall:

22           ~~SECTION 6.~~ 609.713 of the statutes is created to read:

23           **609.713 Essential health benefits; preventive services.** Defined network  
24 plans and preferred provider plans are subject to s. 632.895 (13m) and (14m).

25           ~~SECTION 7.~~ 609.847 of the statutes is created to read:

**SENATE BILL 37**

1           **609.847 Preexisting condition discrimination and certain benefit**  
2           **limits prohibited.** Limited service health organizations, preferred provider plans,  
3           and defined network plans are subject to s. 632.728.

4           ✓ **SECTION 8.** 625.12 (1) (a) of the statutes is amended to read:

5           625.12 (1) (a) Past and prospective loss and expense experience within and  
6           outside of this state, except as provided in s. 632.728.

7           ✓ **SECTION 9.** 625.12 (1) (e) of the statutes is amended to read:

8           625.12 (1) (e) Subject to s. ss. 632.365 and 632.728, all other relevant factors,  
9           including the judgment of technical personnel.

10          ✓ **SECTION 10.** 625.12 (2) of the statutes is amended to read:

11          625.12 (2) **CLASSIFICATION.** Risks Except as provided in s. 632.728, risks may  
12          be classified in any reasonable way for the establishment of rates and minimum  
13          premiums, except that no classifications may be based on race, color, creed or  
14          national origin, and classifications in automobile insurance may not be based on  
15          physical condition or developmental disability as defined in s. 51.01 (5). Subject to  
16          s. ss. 632.365 and 632.728, rates thus produced may be modified for individual risks  
17          in accordance with rating plans or schedules that establish reasonable standards for  
18          measuring probable variations in hazards, expenses, or both. Rates may also be  
19          modified for individual risks under s. 625.13 (2).

20          ✓ **SECTION 11.** 625.15 (1) of the statutes is amended to read:

21          625.15 (1) **RATE MAKING.** An Except as provided in s. 632.728, an insurer may  
22          itself establish rates and supplementary rate information for one or more market  
23          segments based on the factors in s. 625.12 and, if the rates are for motor vehicle  
24          liability insurance, subject to s. 632.365, or the insurer may use rates and  
25          supplementary rate information prepared by a rate service organization, with

**SENATE BILL 37****SECTION 11**

1 average expense factors determined by the rate service organization or with such  
2 modification for its own expense and loss experience as the credibility of that  
3 experience allows.

4 ✓ **SECTION 12.** 628.34 (3) (a) of the statutes is amended to read:

5 628.34 (3) (a) No insurer may unfairly discriminate among policyholders by  
6 charging different premiums or by offering different terms of coverage except on the  
7 basis of classifications related to the nature and the degree of the risk covered or the  
8 expenses involved, subject to ss. 632.365, 632.728, 632.746 and 632.748. Rates are  
9 not unfairly discriminatory if they are averaged broadly among persons insured  
10 under a group, blanket or franchise policy, and terms are not unfairly discriminatory  
11 merely because they are more favorable than in a similar individual policy.

12 ✓ **SECTION 13.** 632.728 of the statutes is created to read:

13 **632.728 Coverage of persons with preexisting conditions; guaranteed**  
14 **issue; benefit limits. (1) DEFINITIONS. In this section:**

15 (a) "Health benefit plan" has the meaning given in s. 632.745 (11).

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

17 (2) **GUARANTEED ISSUE.** (a) Every individual health benefit plan shall accept  
18 every individual in this state who, and every group health benefit plan shall accept  
19 every employer in this state that, applies for coverage, regardless of sexual  
20 orientation, gender identity, or whether or not any employee or individual has a  
21 preexisting condition. A health benefit plan may restrict enrollment in coverage  
22 described in this paragraph to open or special enrollment periods.

23 (b) The commissioner shall establish a statewide open enrollment period of no  
24 shorter than 30 days for every individual health benefit plan to allow individuals,  
25 including individuals who do not have coverage, to enroll in coverage.



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1           (3) PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS. (a) An individual  
2 health benefit plan or a self-insured health plan may not establish rules for the  
3 eligibility of any individual to enroll, or for the continued eligibility of any individual  
4 to remain enrolled, under the plan based on any of the following health  
5 status-related factors in relation to the individual or a dependent of the individual:

6           1. Health status.

7           2. Medical condition, including both physical and mental illnesses.

8           3. Claims experience.

9           4. Receipt of health care.

10          5. Medical history.

11          6. Genetic information.

12          7. Evidence of insurability, including conditions arising out of acts of domestic  
13 violence.

14          8. Disability.

15           (b) An insurer offering an individual health benefit plan or a self-insured  
16 health plan may not require any individual, as a condition of enrollment or continued  
17 enrollment under the plan, to pay, on the basis of any health status-related factor  
18 under par. (a) with respect to the individual or a dependent of the individual, a  
19 premium or contribution or a deductible, copayment, or coinsurance amount that is  
20 greater than the premium or contribution or deductible, copayment, or coinsurance  
21 amount respectively for a similarly situated individual enrolled under the plan.

22           (c) Nothing in this subsection prevents an insurer offering an individual health  
23 benefit plan or a self-insured health plan from establishing premium discounts or  
24 rebates or modifying otherwise applicable cost sharing in return for adherence to  
25 programs of health promotion and disease prevention.

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1           (4) PREMIUM RATE VARIATION. A health benefit plan offered on the individual or  
2 small employer market or a self-insured health plan may vary premium rates for a  
3 specific plan based only on the following considerations:

4           (a) Whether the policy or plan covers an individual or a family.

5           (b) Rating area in the state, as established by the commissioner.

6           (c) Age, except that the rate may not vary by more than 3 to 1 for adults over  
7 the age groups and the age bands shall be consistent with recommendations of the  
8 National Association of Insurance Commissioners.

9           (d) Tobacco use, except that the rate may not vary by more than 1.5 to 1.

10          (5) ANNUAL AND LIFETIME LIMITS. An individual or group health benefit plan or  
11 a self-insured health plan may not establish any of the following:

12          (a) Lifetime limits on the dollar value of benefits for an enrollee or a dependent  
13 of an enrollee under the plan.

14          (b) Annual limits on the dollar value of benefits for an enrollee or a dependent  
15 of an enrollee under the plan.

16          (6) SHORT-TERM PLANS. This section and s. 632.76 apply to every short-term,  
17 limited-duration health insurance policy. In this subsection, "short-term,  
18 limited-duration health insurance policy" means health coverage that is provided  
19 under a contract with an insurer, has an expiration date specified in the contract that  
20 is less than 12 months after the original effective date of the contract, and, taking  
21 into account renewals or extensions, has a duration of no longer than 36 months in  
22 total. "Short-term, limited-duration health insurance policy" includes any  
23 short-term policy subject to s. 632.7495 (4).

24          ✓ **SECTION 14.** 632.746 (1) (a) of the statutes is renumbered 632.746 (1) and  
25 amended to read:

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

8           ✓ SECTION 15. 632.746 (1) (b) of the statutes is repealed.

9           ✓ SECTION 16. 632.746 (2) (a) of the statutes is amended to read:

10           632.746 (2) (a) An insurer offering a group health benefit plan may not ~~treat~~  
11 ~~impose a preexisting condition exclusion based on genetic information as a~~  
12 ~~preexisting condition under sub. (1) without a diagnosis of a condition related to the~~  
13 ~~information.~~

14           ✓ SECTION 17. 632.746 (2) (c), (d) and (e) of the statutes are repealed.

15           ✓ SECTION 18. 632.746 (3) (a) of the statutes is repealed.

16           ✓ SECTION 19. 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

17           ✓ SECTION 20. 632.746 (3) (d) 2. and 3. of the statutes are repealed.

18           ✓ SECTION 21. 632.746 (5) of the statutes is repealed.

19           ✓ SECTION 22. 632.746 (8) (a) (intro.) of the statutes is amended to read:

20           632.746 (8) (a) (intro.) A health maintenance organization that offers a group  
21 health benefit plan and ~~that does not impose any preexisting condition exclusion~~  
22 ~~under sub. (1) with respect to a particular coverage option may impose an affiliation~~  
23 period for that coverage option, but only if all of the following apply:

24           ✓ SECTION 23. 632.748 (2) of the statutes is amended to read:

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## SECTION 23

1           632.748 (2) An insurer offering a group health benefit plan may not require any  
2 individual, as a condition of enrollment or continued enrollment under the plan, to  
3 pay, on the basis of any health status-related factor with respect to the individual  
4 or a dependent of the individual, a premium or contribution or a deductible,  
5 copayment, or coinsurance amount that is greater than the premium or contribution  
6 or deductible, copayment, or coinsurance amount respectively for a similarly  
7 situated individual enrolled under the plan.

8           ✓ **SECTION 24.** 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

9           632.76 (2) (a) No claim for loss incurred or disability commencing after 2 years  
10 from the date of issue of the policy may be reduced or denied on the ground that a  
11 disease or physical condition existed prior to the effective date of coverage, unless the  
12 condition was excluded from coverage by name or specific description by a provision  
13 effective on the date of loss. This paragraph does not apply to a group health benefit  
14 plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance  
15 policy, as defined in s. 632.895 (1) (a), or a self-insured health plan, as defined in s.  
16 632.85 (1) (c).

17           (ac) 1. ~~Notwithstanding par. (a), no~~ No claim or loss incurred or disability  
18 commencing ~~after 12 months from the date of issue of~~ under an individual disability  
19 insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the  
20 ground that a disease or physical condition existed prior to the effective date of  
21 coverage, ~~unless the condition was excluded from coverage by name or specific~~  
22 ~~description by a provision effective on the date of the loss.~~

23           2. ~~Except as provided in subd. 3., an~~ An individual disability insurance policy,  
24 as defined in s. 632.895 (1) (a), ~~other than a short-term policy subject to s. 632.7495~~  
25 ~~(4) and (5), may not define a preexisting condition more restrictively than a condition~~

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1 that was present before the date of enrollment for the coverage, whether physical or  
2 mental, regardless of the cause of the condition, ~~for which and regardless of whether~~  
3 medical advice, diagnosis, care, or treatment was recommended or received ~~within~~  
4 ~~12 months before the effective date of coverage.~~

5 ✓ SECTION 25. 632.76 (2) (ac) 3. of the statutes is repealed.

6 ✓ SECTION 26. 632.795 (4) (a) of the statutes is amended to read:

7 632.795 (4) (a) An insurer subject to sub. (2) shall provide coverage under the  
8 same policy form and for the same premium as it originally offered in the most recent  
9 enrollment period, subject only to the medical underwriting used in that enrollment  
10 period. Unless otherwise prescribed by rule, the insurer may apply deductibles,  
11 ~~preexisting condition limitations~~, waiting periods, or other limits only to the extent  
12 that they would have been applicable had coverage been extended at the time of the  
13 most recent enrollment period and with credit for the satisfaction or partial  
14 satisfaction of similar provisions under the liquidated insurer's policy or plan. The  
15 insurer may exclude coverage of claims that are payable by a solvent insurer under  
16 insolvency coverage required by the commissioner or by the insurance regulator of  
17 another jurisdiction. Coverage shall be effective on the date that the liquidated  
18 insurer's coverage terminates.

19 ✓ SECTION 27. 632.895 (8) (d) of the statutes is amended to read:

20 632.895 (8) (d) Coverage is required under this subsection despite whether the  
21 woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c), and  
22 (e), coverage under this subsection may only be subject to exclusions and limitations,  
23 including ~~deductibles, copayments and restrictions on excessive charges~~, that are  
24 applied to other radiological examinations covered under the disability insurance

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1 policy. Coverage under this subsection may not be subject to any deductibles,  
2 copayments, or coinsurance.

3 ✓ **SECTION 28.** 632.895 (13m) of the statutes is created to read:

4 632.895 (13m) PREVENTIVE SERVICES. (a) In this section, “self-insured health  
5 plan” has the meaning given in s. 632.85 (1) (c).

6 (b) Every disability insurance policy, except any disability insurance policy that  
7 is described in s. 632.745 (11) (b) 1. to 12., and every self-insured health plan shall  
8 provide coverage for all of the following preventive services:

9 1. Mammography in accordance with sub. (8).

10 2. Genetic breast cancer screening and counseling and preventive medication  
11 for adult women at high risk for breast cancer.

12 3. Papanicolaou test for cancer screening for women 21 years of age or older  
13 with an intact cervix.

14 4. Human papillomavirus testing for women who have attained the age of 30  
15 years but have not attained the age of 66 years.

16 5. Colorectal cancer screening in accordance with sub. (16m).

17 6. Annual tomography for lung cancer screening for adults who have attained  
18 the age of 55 years but have not attained the age of 80 years and who have health  
19 histories demonstrating a risk for lung cancer.

20 7. Skin cancer screening for individuals who have attained the age of 10 years  
21 but have not attained the age of 22 years.

22 8. Counseling for skin cancer prevention for adults who have attained the age  
23 of 18 years but have not attained the age of 25 years.

24 9. Abdominal aortic aneurysm screening for men who have attained the age of  
25 65 years but have not attained the age of 75 years and who have ever smoked.

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1           10. Hypertension screening for adults and blood pressure testing for adults, for  
2 children under the age of 3 years who are at high risk for hypertension, and for  
3 children 3 years of age or older.

4           11. Lipid disorder screening for minors 2 years of age or older, adults 20 years  
5 of age or older at high risk for lipid disorders, and all men 35 years of age or older.

6           12. Aspirin therapy for cardiovascular health for adults who have attained the  
7 age of 55 years but have not attained the age of 80 years and for men who have  
8 attained the age of 45 years but have not attained the age of 55 years.

9           13. Behavioral counseling for cardiovascular health for adults who are  
10 overweight or obese and who have risk factors for cardiovascular disease.

11           14. Type II diabetes screening for adults with elevated blood pressure.

12           15. Depression screening for minors 11 years of age or older and for adults when  
13 follow-up supports are available.

14           16. Hepatitis B screening for minors at high risk for infection and adults at high  
15 risk for infection.

16           17. Hepatitis C screening for adults at high risk for infection and one-time  
17 hepatitis C screening for adults born in any year from 1945 to 1965.

18           18. Obesity screening and management for all minors and adults with a body  
19 mass index indicating obesity, counseling and behavioral interventions for obese  
20 minors who are 6 years of age or older, and referral for intervention for obesity for  
21 adults with a body mass index of 30 kilograms per square meter or higher.

22           19. Osteoporosis screening for all women 65 years of age or older and for women  
23 at high risk for osteoporosis under the age of 65 years.

24           20. Immunizations in accordance with sub. (14).

**SENATE BILL 37****SECTION 28**

1           21. Anemia screening for individuals 6 months of age or older and iron  
2 supplements for individuals at high risk for anemia and who have attained the age  
3 of 6 months but have not attained the age of 12 months.

4           22. Fluoride varnish for prevention of tooth decay for minors at the age of  
5 eruption of their primary teeth.

6           23. Fluoride supplements for prevention of tooth decay for minors 6 months of  
7 age or older who do not have fluoride in their water source.

8           24. Gonorrhea prophylaxis treatment for newborns.

9           25. Health history and physical exams for prenatal visits and for minors.

10          26. Length and weight measurements for newborns and height and weight  
11 measurements for minors.

12          27. Head circumference and weight-for-length measurements for newborns  
13 and minors who have not attained the age of 3 years.

14          28. Body mass index for minors 2 years of age or older.

15          29. Blood pressure measurements for minors 3 years of age or older and a blood  
16 pressure risk assessment at birth.

17          30. Risk assessment and referral for oral health issues for minors who have  
18 attained the age of 6 months but have not attained the age of 7 years.

19          31. Blood screening for newborns and minors who have not attained the age of  
20 2 months.

21          32. Screening for critical congenital health defects for newborns.

22          33. Lead screenings in accordance with sub. (10).

23          34. Metabolic and hemoglobin screening and screening for phenylketonuria,  
24 sickle cell anemia, and congenital hypothyroidism for minors including newborns.



**SENATE BILL 37**

1           35. Tuberculin skin test based on risk assessment for minors one month of age  
2 or older.

3           36. Tobacco counseling and cessation interventions for individuals who are 5  
4 years of age or older.

5           37. Vision and hearing screening and assessment for minors including  
6 newborns.

7           38. Sexually transmitted infection and human immunodeficiency virus  
8 counseling for sexually active minors.

9           39. Risk assessment for sexually transmitted infection for minors who are 10  
10 years of age or older and screening for sexually transmitted infection for minors who  
11 are 16 years of age or older.

12           40. Alcohol misuse screening and counseling for minors 11 years of age or older.

13           41. Autism screening for minors who have attained the age of 18 months but  
14 have not attained the age of 25 months.

15           42. Developmental screening and surveillance for minors including newborns.

16           43. Psychosocial and behavioral assessment for minors including newborns.

17           44. Alcohol misuse screening and counseling for pregnant adults and a risk  
18 assessment for all adults.

19           45. Fall prevention and counseling and preventive medication for fall  
20 prevention for community-dwelling adults 65 years of age or older.

21           46. Screening and counseling for intimate partner violence for adult women.

22           47. Well-woman visits for women who have attained the age of 18 years but  
23 have not attained the age of 65 years and well-woman visits for recommended  
24 preventive services, preconception care, and prenatal care.

**SENATE BILL 37**

1           48. Counseling on, consultations with a trained provider on, and equipment  
2 rental for breastfeeding for pregnant and lactating women.

3           49. Folic acid supplement for adult women with reproductive capacity.

4           50. Iron deficiency anemia screening for pregnant and lactating women.

5           51. Preeclampsia preventive medicine for pregnant adult women at high risk  
6 for preeclampsia.

7           52. Low-dose aspirin after 12 weeks of gestation for pregnant women at high  
8 risk for miscarriage, preeclampsia, or clotting disorders.

9           53. Screenings for hepatitis B and bacteriuria for pregnant women.

10          54. Screening for gonorrhea for pregnant and sexually active females 24 years  
11 of age or younger and females older than 24 years of age who are at risk for infection.

12          55. Screening for chlamydia for pregnant and sexually active females 24 years  
13 of age and younger and females older than 24 years of age who are at risk for  
14 infection.

15          56. Screening for syphilis for pregnant women and adults who are at high risk  
16 for infection.

17          57. Human immunodeficiency virus screening for adults who have attained the  
18 age of 15 years but have not attained the age of 66 years and individuals at high risk  
19 of infection who are younger than 15 years of age or older than 65 years of age.

20          58. All contraceptives and services in accordance with sub. (17).

21          59. Any services not already specified under this paragraph having an A or B  
22 rating in current recommendations from the U.S. preventive services task force.

23          60. Any preventive services not already specified under this paragraph that are  
24 recommended by the federal health resources and services administration's Bright  
25 Futures project.

**SENATE BILL 37**

1           61. Any immunizations, not already specified under sub. (14), that are  
2 recommended and determined to be for routine use by the federal advisory  
3 committee on immunization practices.

4           (c) Subject to par. (d), no disability insurance policy and no self-insured health  
5 plan may subject the coverage of any of the preventive services under par. (b) to any  
6 deductibles, copayments, or coinsurance under the policy or plan.

7           (d) 1. If an office visit and a preventive service specified under par. (b) are billed  
8 separately by the health care provider, the disability insurance policy or self-insured  
9 health plan may apply deductibles to and impose copayments or coinsurance on the  
10 office visit but not on the preventive service.

11           2. If the primary reason for an office visit is not to obtain a preventive service,  
12 the disability insurance policy or self-insured health plan may apply deductibles to  
13 and impose copayments or coinsurance on the office visit.

14           3. Except as otherwise provided in this subdivision, if a preventive service  
15 specified under par. (b) is provided by a health care provider that is outside the  
16 disability insurance policy's or self-insured health plan's network of providers, the  
17 policy or plan may apply deductibles to and impose copayments or coinsurance on the  
18 office visit and the preventive service. If a preventive service specified under par. (b)  
19 is provided by a health care provider that is outside the disability insurance policy's  
20 or self-insured health plan's network of providers because there is no available  
21 health care provider in the policy's or plan's network of providers that provides the  
22 preventive service, the policy or plan may not apply deductibles to or impose  
23 copayments or coinsurance on the preventive service.

24           4. If multiple well-woman visits described under par. (b) 47. are required to  
25 fulfill all necessary preventive services and are in accordance with clinical

**SENATE BILL 37****SECTION 28**

1 recommendations, the disability insurance policy or self-insured health plan may  
2 not apply a deductible to or impose a copayment or coinsurance on any of those  
3 well-woman visits.

4 ✓ **SECTION 29.** 632.895 (14) (a) 1. i. and j. of the statutes are amended to read:

5 632.895 (14) (a) 1. i. Hepatitis A and B.

6 j. Varicella and herpes zoster.

7 ✓ **SECTION 30.** 632.895 (14) (a) 1. k. to o. of the statutes are created to read:

8 632.895 (14) (a) 1. k. Human papillomavirus.

9 L. Meningococcal meningitis.

10 m. Pneumococcal pneumonia.

11 n. Influenza.

12 o. Rotavirus.

13 ✓ **SECTION 31.** 632.895 (14) (b) of the statutes is amended to read:

14 632.895 (14) (b) Except as provided in par. (d), every disability insurance policy,  
15 and every self-insured health plan of the state or a county, city, town, village, or  
16 school district, ~~that provides coverage for a dependent of the insured shall provide~~  
17 coverage of appropriate and necessary immunizations, ~~from birth to the age of 6~~  
18 years, for an insured or plan participant, including a dependent who is a child of the  
19 insured or plan participant.

20 ✓ **SECTION 32.** 632.895 (14) (c) of the statutes is amended to read:

21 632.895 (14) (c) The coverage required under par. (b) may not be subject to any  
22 deductibles, copayments, or coinsurance under the policy or plan. ~~This paragraph~~  
23 ~~applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to~~  
24 ~~appropriate and necessary immunizations provided by providers participating, as~~  
25 ~~defined in s. 609.01 (3m), in the plan.~~

**SENATE BILL 37**

1 ✓ **SECTION 33.** 632.895 (14) (d) 3. of the statutes is amended to read:

2 632.895 (14) (d) 3. A health care plan offered by a limited service health  
3 organization, as defined in s. 609.01 (3), ~~or by a preferred provider plan, as defined~~  
4 ~~in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).~~

5 ✓ **SECTION 34.** 632.895 (14m) of the statutes is created to read:

6 632.895 (14m) ESSENTIAL HEALTH BENEFITS. (a) In this subsection,  
7 “self-insured health plan” has the meaning given in s. 632.85 (1) (c).

8 (b) On a date specified by the commissioner, by rule, every disability insurance  
9 policy, except as provided in par. (g), and every self-insured health plan shall provide  
10 coverage for essential health benefits as determined by the commissioner, by rule,  
11 subject to par. (c).

12 (c) In determining the essential health benefits for which coverage is required  
13 under par. (b), the commissioner shall do all of the following:

14 1. Include benefits, items, and services in, at least, all of the following  
15 categories:

16 a. Ambulatory patient services.

17 b. Emergency services.

18 c. Hospitalization.

19 d. Maternity and newborn care.

20 e. Mental health and substance use disorder services, including behavioral  
21 health treatment.

22 f. Prescription drugs.

23 g. Rehabilitative and habilitative services and devices.

24 h. Laboratory services.

25 i. Preventive and wellness services and chronic disease management.

**SENATE BILL 37****SECTION 34**

1           j. Pediatric services, including oral and vision care.

2           2. Conduct a survey of employer-sponsored coverage to determine benefits  
3 typically covered by employers and ensure that the scope of essential health benefits  
4 for which coverage is required under this subsection is equal to the scope of benefits  
5 covered under a typical disability insurance policy offered by an employer to its  
6 employees.

7           3. Ensure that essential health benefits reflect a balance among the categories  
8 described in subd. 1. such that benefits are not unduly weighted toward one category.

9           4. Ensure that essential health benefit coverage is provided with no or limited  
10 cost-sharing requirements.

11           5. Require that disability insurance policies and self-insured health plans do  
12 not make coverage decisions, determine reimbursement rates, establish incentive  
13 programs, or design benefits in ways that discriminate against individuals because  
14 of their age, disability, or expected length of life.

15           6. Establish essential health benefits in a way that takes into account the  
16 health care needs of diverse segments of the population, including women, children,  
17 persons with disabilities, and other groups.

18           7. Ensure that essential health benefits established under this subsection are  
19 not subject to a coverage denial based on an insured's or plan participant's age,  
20 expected length of life, present or predicted disability, degree of dependency on  
21 medical care, or quality of life.

22           8. Require that disability insurance policies and self-insured health plans  
23 cover emergency department services that are essential health benefits without  
24 imposing any requirement to obtain prior authorization for those services and  
25 without limiting coverage for services provided by an emergency services provider

**SENATE BILL 37**

1 that is not in the provider network of a policy or plan in a way that is more restrictive  
2 than requirements or limitations that apply to emergency services provided by a  
3 provider that is in the provider network of the policy or plan.

4 9. Require a disability insurance policy or self-insured health plan to apply to  
5 emergency department services that are essential health benefits provided by an  
6 emergency department provider that is not in the provider network of the policy or  
7 plan the same copayment amount or coinsurance rate that applies if those services  
8 are provided by a provider that is in the provider network of the policy or plan.

9 (d) The commissioner shall periodically update, by rule, the essential health  
10 benefits under this subsection to address any gaps in access to coverage.

11 (e) If an essential health benefit is also subject to mandated coverage elsewhere  
12 under this section and the coverage requirements are not identical, the disability  
13 insurance policy or self-insured health plan shall provide coverage under whichever  
14 subsection provides the insured or plan participant with more comprehensive  
15 coverage of the medical condition, item, or service.

16 (f) Nothing in this subsection or rules promulgated under this subsection  
17 prohibits a disability insurance policy or a self-insured health plan from providing  
18 benefits in excess of the essential health benefit coverage required under this  
19 subsection.

20 (g) This subsection does not apply to any disability insurance policy that is  
21 described in s. 632.745 (11) (b) 1. to 12.

22 ✓ **SECTION 35.** 632.895 (16m) (b) of the statutes is amended to read:

23 632.895 (16m) (b) The coverage required under this subsection may be subject  
24 to any limitations, or exclusions, ~~or cost-sharing provisions~~ that apply generally  
25 under the disability insurance policy or self-insured health plan. The coverage

## SENATE BILL 37

## SECTION 35

1 required under this subsection may not be subject to any deductibles, copayments,  
2 or coinsurance.

3 ✓ SECTION 36. 632.895 (17) (b) 2. of the statutes is amended to read:

4 632.895 (17) (b) 2. Outpatient consultations, examinations, procedures, and  
5 medical services that are necessary to prescribe, administer, maintain, or remove a  
6 contraceptive, ~~if covered for any other drug benefits under the policy or plan~~  
7 sterilization procedures, and patient education and counseling for all females with  
8 reproductive capacity.

9 ✓ SECTION 37. 632.895 (17) (c) of the statutes is amended to read:

10 632.895 (17) (c) Coverage under par. (b) may be subject only to the exclusions,  
11 and limitations, or cost-sharing provisions that apply generally to the coverage of  
12 outpatient health care services, preventive treatments and services, or prescription  
13 drugs and devices that is provided under the policy or self-insured health plan. A  
14 disability insurance policy or self-insured health plan may not apply a deductible or  
15 impose a copayment or coinsurance to at least one of each type of contraceptive  
16 method approved by the federal food and drug administration for which coverage is  
17 required under this subsection. The disability insurance policy or self-insured  
18 health plan may apply reasonable medical management to a method of contraception  
19 to limit coverage under this subsection that is provided without being subject to a  
20 deductible, copayment, or coinsurance to prescription drugs without a brand name.  
21 The disability insurance policy or self-insured health plan may apply a deductible  
22 or impose a copayment or coinsurance for coverage of a contraceptive that is  
23 prescribed for a medical need if the services for the medical need would otherwise be  
24 subject to a deductible, copayment, or coinsurance.

25 ✓ SECTION 38. 632.897 (11) (a) of the statutes is amended to read:



**SENATE BILL 37**

1           632.897 (11) (a) Notwithstanding subs. (2) to (10), the commissioner may  
2 promulgate rules establishing standards requiring insurers to provide continuation  
3 of coverage for any individual covered at any time under a group policy who is a  
4 terminated insured or an eligible individual under any federal program that  
5 provides for a federal premium subsidy for individuals covered under continuation  
6 of coverage under a group policy, including rules governing election or extension of  
7 election periods, notice, rates, premiums, premium payment, application of  
8 ~~preexisting condition exclusions~~, election of alternative coverage, and status as an  
9 eligible individual, as defined in s. 149.10 (2t), 2011 stats.

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23-10 →

**SECTION 39. Initial applicability.**

(1) For policies and plans containing provisions inconsistent with this act, this act first applies to policy or plan years beginning on January 1 of the year following the year in which this subsection takes effect, except as provided in sub. (2).

(2) 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 subsection or on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.

**SECTION 40. Effective date.**

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

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**SECTION 9323. Initial applicability; Insurance.**

(1) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES. (a) For policies and plans containing provisions inconsistent with these sections, the treatment of ss. 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, 609.847, 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1., 2., and 3., 632.795 (4) (a), 632.895 (8) (d), (14) (a) 1. i., j., and k. to o., (b), (c) and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c) and 632.897 (11) (a) first applies to policy or plan years beginning on January 1 of the year following the year in which this subsection takes effect, except as provided in par. (b).

Paragraph

¶

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(b) For policies and plans that are affected by a collective bargaining agreement containing provisions inconsistent with these sections, the treatment of ss. 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, 609.847, 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1., 2., and 3., 632.795 (4) (a), 632.895 (8) (d), (14) (a) 1. i., j., and k. to o., (b), (c) and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c) and 632.897 (11) (a) first applies to policy or plan years beginning on the effective date of this subsection or on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.

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Paragraph

**SECTION 9423. Effective dates; Insurance.**

(13m) ↗

1 (1) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH  
 2 BENEFITS, AND PREVENTIVE SERVICES. The treatment of ss. 40.51 (8), 40.51 (8m),  
 3 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, 609.847, 625.12 (1) (a) and  
 4 (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d),  
 5 and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a)  
 6 and (ac) 1., 2., and 3., 632.795 (4) (a), 632.895 (8) (d), (14) (a) 1. i., j., and k. to o., (b),  
 7 (c) and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c) and 632.897 (11) (a) and SECTION  
 8 9323 (AR) of this act take effect on the first day of the 4th month beginning after  
 9 publication.

10 END INSERT 23-10

and

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State of Wisconsin  
2019 - 2020 LEGISLATURE

LRB-2091/P1  
TJD:cjs&wlj

DOA:.....Ames, BB0405 - Preexisting conditions coverage

**FOR 2019-2021 BUDGET -- NOT READY FOR INTRODUCTION**

1 **AN ACT relating to:** the budget.

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*Analysis by the Legislative Reference Bureau*

**INSURANCE**

**1. Coverage of individuals with preexisting conditions, essential health benefits, and preventive services**

This bill requires certain health plans to guarantee access to coverage; prohibits plans from imposing preexisting condition exclusions; prohibits plans from setting premiums or cost-sharing amounts based on a health status-related factors; prohibits plans from setting lifetime or annual limits on benefits; requires plans to cover certain essential health benefits; and requires coverage of certain preventive services by plans without a cost-sharing contribution by an enrollee.

This bill requires every individual health insurance policy, known in the bill as a health benefit plan, to accept every individual who, and every group health insurance policy to accept every employer that, applies for coverage, regardless of sexual orientation, gender identity, or whether an employee or individual has a preexisting condition. The bill allows health benefit plans to restrict enrollment in coverage to open or special enrollment periods and requires the commissioner of insurance to establish a statewide open enrollment period of no shorter than 30 days for every individual health benefit plan. The bill prohibits a group health insurance policy, including a self-insured governmental health plan, from imposing a preexisting condition exclusion. The bill also prohibits an individual health 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.

A health benefit plan offered on the individual or small employer market or a self-insured governmental health plan may not vary premium rates for a specific plan except on the basis of whether the plan covers an individual or family, area in the state, age, and tobacco use as specified in the bill. An individual health benefit plan or self-insured health plan is prohibited under the bill from establishing rules for the eligibility of any individual to enroll based on health-status related factors, which are specified in the bill. A self-insured health plan or an insurer offering an individual health benefit plan is also prohibited from requiring an enrollee to pay a greater premium, contribution, deductible, copayment, or coinsurance amount than is required of a similarly situated enrollee based on a health-status related factor. Current state law prohibits group health benefit plans from establishing rules of eligibility or requiring greater premium or contribution amounts based on a health-status related factor. The bill adds to these current law requirements for group health benefit plans that the plan may not require a greater deductible, copayment, or coinsurance amount based on a health-status related factor.

Under the bill, an individual or group health benefit plan or a self-insured governmental health plan may not establish lifetime or annual limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the plan.

The requirements and prohibitions in this bill related to coverage of individuals with preexisting conditions and prohibition of lifetime and annual benefit limits also apply to short-term, limited-duration health insurance policies.

This bill requires certain health insurance policies, known in the bill as disability insurance policies, and governmental self-insured health plans to cover essential health benefits that will be specified by the commissioner of insurance by rule. The bill specifies a list of requirements that the commissioner must follow when establishing the essential health benefits including certain limitations on cost sharing and the following general categories of benefits, items, or services in which the commissioner must require coverage: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services. If an essential health benefit specified by the commissioner is also subject to its own mandated coverage requirement, the bill requires the disability insurance policy or self-insured health plan to provide coverage under whichever requirement provides the insured or plan participant with more comprehensive coverage.

This bill requires health insurance policies and governmental self-insured health plans to cover certain preventive services and to provide coverage of those preventive services without subjecting that coverage to deductibles, copayments, or coinsurance. The preventive services for which coverage is required are specified in the bill. The bill also specifies certain instances when cost-sharing amounts may be charged for an office visit associated with a preventive service.

This proposal may contain a health insurance mandate requiring a social and financial impact report under s. 601.423, stats.

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

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

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

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

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

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

13           66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or  
14 a village provides health care benefits under its home rule power, or if a town  
15 provides health care benefits, to its officers and employees on a self-insured basis,  
16 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),  
17 632.728, 632.746 (1) and (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853,  
18 632.855, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 ~~(9)~~ (8) to (17), 632.896,  
19 and 767.513 (4).

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

1           120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.  
2 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.746 (1) and (10) (a) 2. and (b)  
3 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.885,  
4 632.89, 632.895 (9) (8) to (17), 632.896, and 767.513 (4).

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

6           185.983 (1) (intro.) Every voluntary nonprofit health care plan operated by a  
7 cooperative association organized under s. 185.981 shall be exempt from chs. 600 to  
8 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44,  
9 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93,  
10 631.95, 632.72 (2), 632.728, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798,  
11 632.85, 632.853, 632.855, 632.867, 632.87 (2) to (6), 632.885, 632.89, 632.895 (5) and  
12 (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but  
13 the sponsoring association shall:

14           **SECTION 6.** 609.713 of the statutes is created to read:

15           **609.713 Essential health benefits; preventive services.** Defined network  
16 plans and preferred provider plans are subject to s. 632.895 (13m) and (14m).

17           **SECTION 7.** 609.847 of the statutes is created to read:

18           **609.847 Preexisting condition discrimination and certain benefit**  
19 **limits prohibited.** Limited service health organizations, preferred provider plans,  
20 and defined network plans are subject to s. 632.728.

21           **SECTION 8.** 625.12 (1) (a) of the statutes is amended to read:

22           625.12 (1) (a) Past and prospective loss and expense experience within and  
23 outside of this state, except as provided in s. 632.728.

24           **SECTION 9.** 625.12 (1) (e) of the statutes is amended to read:

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

3           **SECTION 10.** 625.12 (2) of the statutes is amended to read:

4           625.12 (2) CLASSIFICATION. Risks Except as provided in s. 632.728, risks may  
5 be classified in any reasonable way for the establishment of rates and minimum  
6 premiums, except that no classifications may be based on race, color, creed or  
7 national origin, and classifications in automobile insurance may not be based on  
8 physical condition or developmental disability as defined in s. 51.01 (5). Subject to  
9 s. ss. 632.365 and 632.728, rates thus produced may be modified for individual risks  
10 in accordance with rating plans or schedules that establish reasonable standards for  
11 measuring probable variations in hazards, expenses, or both. Rates may also be  
12 modified for individual risks under s. 625.13 (2).

13           **SECTION 11.** 625.15 (1) of the statutes is amended to read:

14           625.15 (1) RATE MAKING. An Except as provided in s. 632.728, an insurer may  
15 itself establish rates and supplementary rate information for one or more market  
16 segments based on the factors in s. 625.12 and, if the rates are for motor vehicle  
17 liability insurance, subject to s. 632.365, or the insurer may use rates and  
18 supplementary rate information prepared by a rate service organization, with  
19 average expense factors determined by the rate service organization or with such  
20 modification for its own expense and loss experience as the credibility of that  
21 experience allows.

22           **SECTION 12.** 628.34 (3) (a) of the statutes is amended to read:

23           628.34 (3) (a) No insurer may unfairly discriminate among policyholders by  
24 charging different premiums or by offering different terms of coverage except on the  
25 basis of classifications related to the nature and the degree of the risk covered or the



1 expenses involved, subject to ss. 632.365, 632.728, 632.746 and 632.748. Rates are  
2 not unfairly discriminatory if they are averaged broadly among persons insured  
3 under a group, blanket or franchise policy, and terms are not unfairly discriminatory  
4 merely because they are more favorable than in a similar individual policy.

5 **SECTION 13.** 632.728 of the statutes is created to read:

6 **632.728 Coverage of persons with preexisting conditions; guaranteed**  
7 **issue; benefit limits. (1) DEFINITIONS.** In this section:

8 (a) "Health benefit plan" has the meaning given in s. 632.745 (11).

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

10 **(2) GUARANTEED ISSUE.** (a) Every individual health benefit plan shall accept  
11 every individual in this state who, and every group health benefit plan shall accept  
12 every employer in this state that, applies for coverage, regardless of sexual  
13 orientation, gender identity, or whether or not any employee or individual has a  
14 preexisting condition. A health benefit plan may restrict enrollment in coverage  
15 described in this paragraph to open or special enrollment periods.

16 (b) The commissioner shall establish a statewide open enrollment period of no  
17 shorter than 30 days for every individual health benefit plan to allow individuals,  
18 including individuals who do not have coverage, to enroll in coverage.

19 **(3) PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS.** (a) An individual  
20 health benefit plan or a self-insured health plan may not establish rules for the  
21 eligibility of any individual to enroll, or for the continued eligibility of any individual  
22 to remain enrolled, under the plan based on any of the following health  
23 status-related factors in relation to the individual or a dependent of the individual:

24 1. Health status.

25 2. Medical condition, including both physical and mental illnesses.

- 1           3. Claims experience.
- 2           4. Receipt of health care.
- 3           5. Medical history.
- 4           6. Genetic information.
- 5           7. Evidence of insurability, including conditions arising out of acts of domestic
- 6 violence.
- 7           8. Disability.

8           (b) An insurer offering an individual health benefit plan or a self-insured  
9 health plan may not require any individual, as a condition of enrollment or continued  
10 enrollment under the plan, to pay, on the basis of any health status-related factor  
11 under par. (a) with respect to the individual or a dependent of the individual, a  
12 premium or contribution or a deductible, copayment, or coinsurance amount that is  
13 greater than the premium or contribution or deductible, copayment, or coinsurance  
14 amount respectively for a similarly situated individual enrolled under the plan.

15           (c) Nothing in this subsection prevents an insurer offering an individual health  
16 benefit plan or a self-insured health plan from establishing premium discounts or  
17 rebates or modifying otherwise applicable cost sharing in return for adherence to  
18 programs of health promotion and disease prevention.

19           **(4) PREMIUM RATE VARIATION.** A health benefit plan offered on the individual or  
20 small employer market or a self-insured health plan may vary premium rates for a  
21 specific plan based only on the following considerations:

- 22           (a) Whether the policy or plan covers an individual or a family.
- 23           (b) Rating area in the state, as established by the commissioner.

1 (c) Age, except that the rate may not vary by more than 3 to 1 for adults over  
2 the age groups and the age bands shall be consistent with recommendations of the  
3 National Association of Insurance Commissioners.

4 (d) Tobacco use, except that the rate may not vary by more than 1.5 to 1.

5 **(5) ANNUAL AND LIFETIME LIMITS.** An individual or group health benefit plan or  
6 a self-insured health plan may not establish any of the following:

7 (a) Lifetime limits on the dollar value of benefits for an enrollee or a dependent  
8 of an enrollee under the plan.

9 (b) Annual limits on the dollar value of benefits for an enrollee or a dependent  
10 of an enrollee under the plan.

11 **(6) SHORT-TERM PLANS.** This section and s. 632.76 apply to every short-term,  
12 limited-duration health insurance policy. In this subsection, "short-term,  
13 limited-duration health insurance policy" means health coverage that is provided  
14 under a contract with an insurer, has an expiration date specified in the contract that  
15 is less than 12 months after the original effective date of the contract, and, taking  
16 into account renewals or extensions, has a duration of no longer than 36 months in  
17 total. "Short-term, limited-duration health insurance policy" includes any  
18 short-term policy subject to s. 632.7495 (4).

19 **SECTION 14.** 632.746 (1) (a) of the statutes is renumbered 632.746 (1) and  
20 amended to read:

21 632.746 (1) ~~Subject to subs. (2) and (3), an An~~ insurer that offers a group health  
22 benefit plan may, ~~with respect to a participant or beneficiary under the plan, not~~  
23 impose a preexisting condition exclusion only if the exclusion relates to a condition,  
24 whether physical or mental, regardless of the cause of the condition, for which  
25 medical advice, diagnosis, care or treatment was recommended or received within

1 ~~the 6-month period ending on the participant's or beneficiary's enrollment date~~  
2 ~~under the plan on a participant or beneficiary under the plan.~~

3 **SECTION 15.** 632.746 (1) (b) of the statutes is repealed.

4 **SECTION 16.** 632.746 (2) (a) of the statutes is amended to read:

5 632.746 (2) (a) An insurer offering a group health benefit plan may not treat  
6 impose a preexisting condition exclusion based on genetic information ~~as a~~  
7 ~~preexisting condition under sub. (1) without a diagnosis of a condition related to the~~  
8 ~~information.~~

9 **SECTION 17.** 632.746 (2) (c), (d) and (e) of the statutes are repealed.

10 **SECTION 18.** 632.746 (3) (a) of the statutes is repealed.

11 **SECTION 19.** 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

12 **SECTION 20.** 632.746 (3) (d) 2. and 3. of the statutes are repealed.

13 **SECTION 21.** 632.746 (5) of the statutes is repealed.

14 **SECTION 22.** 632.746 (8) (a) (intro.) of the statutes is amended to read:

15 632.746 (8) (a) (intro.) A health maintenance organization that offers a group  
16 health benefit plan ~~and that does not impose any preexisting condition exclusion~~  
17 ~~under sub. (1) with respect to a particular coverage option may impose an affiliation~~  
18 ~~period for that coverage option, but only if all of the following apply:~~

19 **SECTION 23.** 632.748 (2) of the statutes is amended to read:

20 632.748 (2) An insurer offering a group health benefit plan may not require any  
21 individual, as a condition of enrollment or continued enrollment under the plan, to  
22 pay, on the basis of any health status-related factor with respect to the individual  
23 or a dependent of the individual, a premium or contribution or a deductible,  
24 copayment, or coinsurance amount that is greater than the premium or contribution

1 or deductible, copayment, or coinsurance amount respectively for a similarly  
2 situated individual enrolled under the plan.

3 **SECTION 24.** 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

4 632.76 (2) (a) No claim for loss incurred or disability commencing after 2 years  
5 from the date of issue of the policy may be reduced or denied on the ground that a  
6 disease or physical condition existed prior to the effective date of coverage, unless the  
7 condition was excluded from coverage by name or specific description by a provision  
8 effective on the date of loss. This paragraph does not apply to a group health benefit  
9 plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance  
10 policy, as defined in s. 632.895 (1) (a), or a self-insured health plan, as defined in s.  
11 632.85 (1) (c).

12 (ac) 1. ~~Notwithstanding par. (a), no~~ No claim or loss incurred or disability  
13 commencing after ~~12 months from the date of issue of~~ under an individual disability  
14 insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the  
15 ground that a disease or physical condition existed prior to the effective date of  
16 coverage, unless the condition was excluded from coverage by name or specific  
17 description by a provision effective on the date of the loss.

18 2. ~~Except as provided in subd. 3., an~~ An individual disability insurance policy,  
19 as defined in s. 632.895 (1) (a), ~~other than a short-term policy subject to s. 632.7495~~  
20 ~~(4) and (5), may not define a preexisting condition more restrictively than a condition~~  
21 that was present before the date of enrollment for the coverage, whether physical or  
22 mental, regardless of the cause of the condition, for which and regardless of whether  
23 medical advice, diagnosis, care, or treatment was recommended or received within  
24 12 months before the effective date of coverage.

25 **SECTION 25.** 632.76 (2) (ac) 3. of the statutes is repealed.

1           **SECTION 26.** 632.795 (4) (a) of the statutes is amended to read:

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

14           **SECTION 27.** 632.895 (8) (d) of the statutes is amended to read:

15           632.895 (8) (d) Coverage is required under this subsection despite whether the  
16 woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c), and  
17 (e), coverage under this subsection may only be subject to exclusions and limitations,  
18 including ~~deductibles, copayments and~~ restrictions on excessive charges, that are  
19 applied to other radiological examinations covered under the disability insurance  
20 policy. Coverage under this subsection may not be subject to any deductibles,  
21 copayments, or coinsurance.

22           **SECTION 28.** 632.895 (13m) of the statutes is created to read:

23           632.895 (13m) PREVENTIVE SERVICES. (a) In this section, "self-insured health  
24 plan" has the meaning given in s. 632.85 (1) (c).

1 (b) Every disability insurance policy, except any disability insurance policy that  
2 is described in s. 632.745 (11) (b) 1. to 12., and every self-insured health plan shall  
3 provide coverage for all of the following preventive services:

4 1. Mammography in accordance with sub. (8).

5 2. Genetic breast cancer screening and counseling and preventive medication  
6 for adult women at high risk for breast cancer.

7 3. Papanicolaou test for cancer screening for women 21 years of age or older  
8 with an intact cervix.

9 4. Human papillomavirus testing for women who have attained the age of 30  
10 years but have not attained the age of 66 years.

11 5. Colorectal cancer screening in accordance with sub. (16m).

12 6. Annual tomography for lung cancer screening for adults who have attained  
13 the age of 55 years but have not attained the age of 80 years and who have health  
14 histories demonstrating a risk for lung cancer.

15 7. Skin cancer screening for individuals who have attained the age of 10 years  
16 but have not attained the age of 22 years.

17 8. Counseling for skin cancer prevention for adults who have attained the age  
18 of 18 years but have not attained the age of 25 years.

19 9. Abdominal aortic aneurysm screening for men who have attained the age of  
20 65 years but have not attained the age of 75 years and who have ever smoked.

21 10. Hypertension screening for adults and blood pressure testing for adults, for  
22 children under the age of 3 years who are at high risk for hypertension, and for  
23 children 3 years of age or older.

24 11. Lipid disorder screening for minors 2 years of age or older, adults 20 years  
25 of age or older at high risk for lipid disorders, and all men 35 years of age or older.

1           12. Aspirin therapy for cardiovascular health for adults who have attained the  
2 age of 55 years but have not attained the age of 80 years and for men who have  
3 attained the age of 45 years but have not attained the age of 55 years.

4           13. Behavioral counseling for cardiovascular health for adults who are  
5 overweight or obese and who have risk factors for cardiovascular disease.

6           14. Type II diabetes screening for adults with elevated blood pressure.

7           15. Depression screening for minors 11 years of age or older and for adults when  
8 follow-up supports are available.

9           16. Hepatitis B screening for minors at high risk for infection and adults at high  
10 risk for infection.

11           17. Hepatitis C screening for adults at high risk for infection and one-time  
12 hepatitis C screening for adults born in any year from 1945 to 1965.

13           18. Obesity screening and management for all minors and adults with a body  
14 mass index indicating obesity, counseling and behavioral interventions for obese  
15 minors who are 6 years of age or older, and referral for intervention for obesity for  
16 adults with a body mass index of 30 kilograms per square meter or higher.

17           19. Osteoporosis screening for all women 65 years of age or older and for women  
18 at high risk for osteoporosis under the age of 65 years.

19           20. Immunizations in accordance with sub. (14).

20           21. Anemia screening for individuals 6 months of age or older and iron  
21 supplements for individuals at high risk for anemia and who have attained the age  
22 of 6 months but have not attained the age of 12 months.

23           22. Fluoride varnish for prevention of tooth decay for minors at the age of  
24 eruption of their primary teeth.



1           23. Fluoride supplements for prevention of tooth decay for minors 6 months of  
2 age or older who do not have fluoride in their water source.

3           24. Gonorrhea prophylaxis treatment for newborns.

4           25. Health history and physical exams for prenatal visits and for minors.

5           26. Length and weight measurements for newborns and height and weight  
6 measurements for minors.

7           27. Head circumference and weight-for-length measurements for newborns  
8 and minors who have not attained the age of 3 years.

9           28. Body mass index for minors 2 years of age or older.

10          29. Blood pressure measurements for minors 3 years of age or older and a blood  
11 pressure risk assessment at birth.

12          30. Risk assessment and referral for oral health issues for minors who have  
13 attained the age of 6 months but have not attained the age of 7 years.

14          31. Blood screening for newborns and minors who have not attained the age of  
15 2 months.

16          32. Screening for critical congenital health defects for newborns.

17          33. Lead screenings in accordance with sub. (10).

18          34. Metabolic and hemoglobin screening and screening for phenylketonuria,  
19 sickle cell anemia, and congenital hypothyroidism for minors including newborns.

20          35. Tuberculin skin test based on risk assessment for minors one month of age  
21 or older.

22          36. Tobacco counseling and cessation interventions for individuals who are 5  
23 years of age or older.

24          37. Vision and hearing screening and assessment for minors including  
25 newborns.

1           38. Sexually transmitted infection and human immunodeficiency virus  
2 counseling for sexually active minors.

3           39. Risk assessment for sexually transmitted infection for minors who are 10  
4 years of age or older and screening for sexually transmitted infection for minors who  
5 are 16 years of age or older.

6           40. Alcohol misuse screening and counseling for minors 11 years of age or older.

7           41. Autism screening for minors who have attained the age of 18 months but  
8 have not attained the age of 25 months.

9           42. Developmental screening and surveillance for minors including newborns.

10          43. Psychosocial and behavioral assessment for minors including newborns.

11          44. Alcohol misuse screening and counseling for pregnant adults and a risk  
12 assessment for all adults.

13          45. Fall prevention and counseling and preventive medication for fall  
14 prevention for community-dwelling adults 65 years of age or older.

15          46. Screening and counseling for intimate partner violence for adult women.

16          47. Well-woman visits for women who have attained the age of 18 years but  
17 have not attained the age of 65 years and well-woman visits for recommended  
18 preventive services, preconception care, and prenatal care.

19          48. Counseling on, consultations with a trained provider on, and equipment  
20 rental for breastfeeding for pregnant and lactating women.

21          49. Folic acid supplement for adult women with reproductive capacity.

22          50. Iron deficiency anemia screening for pregnant and lactating women.

23          51. Preeclampsia preventive medicine for pregnant adult women at high risk  
24 for preeclampsia.

1           52. Low-dose aspirin after 12 weeks of gestation for pregnant women at high  
2 risk for miscarriage, preeclampsia, or clotting disorders.

3           53. Screenings for hepatitis B and bacteriuria for pregnant women.

4           54. Screening for gonorrhea for pregnant and sexually active females 24 years  
5 of age or younger and females older than 24 years of age who are at risk for infection.

6           55. Screening for chlamydia for pregnant and sexually active females 24 years  
7 of age and younger and females older than 24 years of age who are at risk for  
8 infection.

9           56. Screening for syphilis for pregnant women and adults who are at high risk  
10 for infection.

11           57. Human immunodeficiency virus screening for adults who have attained the  
12 age of 15 years but have not attained the age of 66 years and individuals at high risk  
13 of infection who are younger than 15 years of age or older than 65 years of age.

14           58. All contraceptives and services in accordance with sub. (17).

15           59. Any services not already specified under this paragraph having an A or B  
16 rating in current recommendations from the U.S. preventive services task force.

17           60. Any preventive services not already specified under this paragraph that are  
18 recommended by the federal health resources and services administration's Bright  
19 Futures project.

20           61. Any immunizations, not already specified under sub. (14), that are  
21 recommended and determined to be for routine use by the federal advisory  
22 committee on immunization practices.

23           (c) Subject to par. (d), no disability insurance policy and no self-insured health  
24 plan may subject the coverage of any of the preventive services under par. (b) to any  
25 deductibles, copayments, or coinsurance under the policy or plan.

1 (d) 1. If an office visit and a preventive service specified under par. (b) are billed  
2 separately by the health care provider, the disability insurance policy or self-insured  
3 health plan may apply deductibles to and impose copayments or coinsurance on the  
4 office visit but not on the preventive service.

5 2. If the primary reason for an office visit is not to obtain a preventive service,  
6 the disability insurance policy or self-insured health plan may apply deductibles to  
7 and impose copayments or coinsurance on the office visit.

8 3. Except as otherwise provided in this subdivision, if a preventive service  
9 specified under par. (b) is provided by a health care provider that is outside the  
10 disability insurance policy's or self-insured health plan's network of providers, the  
11 policy or plan may apply deductibles to and impose copayments or coinsurance on the  
12 office visit and the preventive service. If a preventive service specified under par. (b)  
13 is provided by a health care provider that is outside the disability insurance policy's  
14 or self-insured health plan's network of providers because there is no available  
15 health care provider in the policy's or plan's network of providers that provides the  
16 preventive service, the policy or plan may not apply deductibles to or impose  
17 copayments or coinsurance on the preventive service.

18 4. If multiple well-woman visits described under par. (b) 47. are required to  
19 fulfill all necessary preventive services and are in accordance with clinical  
20 recommendations, the disability insurance policy or self-insured health plan may  
21 not apply a deductible to or impose a copayment or coinsurance on any of those  
22 well-woman visits.

23 **SECTION 29.** 632.895 (14) (a) 1. i. and j. of the statutes are amended to read:

24 632.895 (14) (a) 1. i. Hepatitis A and B.

25 j. Varicella and herpes zoster.

1           **SECTION 30.** 632.895 (14) (a) 1. k. to o. of the statutes are created to read:

2           632.895 (14) (a) 1. k. Human papillomavirus.

3           L. Meningococcal meningitis.

4           m. Pneumococcal pneumonia.

5           n. Influenza.

6           o. Rotavirus.

7           **SECTION 31.** 632.895 (14) (b) of the statutes is amended to read:

8           632.895 (14) (b) Except as provided in par. (d), every disability insurance policy,  
9           and every self-insured health plan of the state or a county, city, town, village, or  
10           school district, that provides coverage for a dependent of the insured shall provide  
11           coverage of appropriate and necessary immunizations, from birth to the age of 6  
12           years, for an insured or plan participant, including a dependent who is a child of the  
13           insured or plan participant.

14           **SECTION 32.** 632.895 (14) (c) of the statutes is amended to read:

15           632.895 (14) (c) The coverage required under par. (b) may not be subject to any  
16           deductibles, copayments, or coinsurance under the policy or plan. ~~This paragraph~~  
17           ~~applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to~~  
18           ~~appropriate and necessary immunizations provided by providers participating, as~~  
19           ~~defined in s. 609.01 (3m), in the plan.~~

20           **SECTION 33.** 632.895 (14) (d) 3. of the statutes is amended to read:

21           632.895 (14) (d) 3. A health care plan offered by a limited service health  
22           organization, as defined in s. 609.01 (3), ~~or by a preferred provider plan, as defined~~  
23           ~~in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).~~

24           **SECTION 34.** 632.895 (14m) of the statutes is created to read:

1           632.895 (14m) ESSENTIAL HEALTH BENEFITS. (a) In this subsection,  
2 “self-insured health plan” has the meaning given in s. 632.85 (1) (c).

3           (b) On a date specified by the commissioner, by rule, every disability insurance  
4 policy, except as provided in par. (g), and every self-insured health plan shall provide  
5 coverage for essential health benefits as determined by the commissioner, by rule,  
6 subject to par. (c).

7           (c) In determining the essential health benefits for which coverage is required  
8 under par. (b), the commissioner shall do all of the following:

9           1. Include benefits, items, and services in, at least, all of the following  
10 categories:

11           a. Ambulatory patient services.

12           b. Emergency services.

13           c. Hospitalization.

14           d. Maternity and newborn care.

15           e. Mental health and substance use disorder services, including behavioral  
16 health treatment.

17           f. Prescription drugs.

18           g. Rehabilitative and habilitative services and devices.

19           h. Laboratory services.

20           i. Preventive and wellness services and chronic disease management.

21           j. Pediatric services, including oral and vision care.

22           2. Conduct a survey of employer-sponsored coverage to determine benefits  
23 typically covered by employers and ensure that the scope of essential health benefits  
24 for which coverage is required under this subsection is equal to the scope of benefits

1 covered under a typical disability insurance policy offered by an employer to its  
2 employees.

3 3. Ensure that essential health benefits reflect a balance among the categories  
4 described in subd. 1. such that benefits are not unduly weighted toward one category.

5 4. Ensure that essential health benefit coverage is provided with no or limited  
6 cost-sharing requirements.

7 5. Require that disability insurance policies and self-insured health plans do  
8 not make coverage decisions, determine reimbursement rates, establish incentive  
9 programs, or design benefits in ways that discriminate against individuals because  
10 of their age, disability, or expected length of life.

11 6. Establish essential health benefits in a way that takes into account the  
12 health care needs of diverse segments of the population, including women, children,  
13 persons with disabilities, and other groups.

14 7. Ensure that essential health benefits established under this subsection are  
15 not subject to a coverage denial based on an insured's or plan participant's age,  
16 expected length of life, present or predicted disability, degree of dependency on  
17 medical care, or quality of life.

18 8. Require that disability insurance policies and self-insured health plans  
19 cover emergency department services that are essential health benefits without  
20 imposing any requirement to obtain prior authorization for those services and  
21 without limiting coverage for services provided by an emergency services provider  
22 that is not in the provider network of a policy or plan in a way that is more restrictive  
23 than requirements or limitations that apply to emergency services provided by a  
24 provider that is in the provider network of the policy or plan.

1           9. Require a disability insurance policy or self-insured health plan to apply to  
2 emergency department services that are essential health benefits provided by an  
3 emergency department provider that is not in the provider network of the policy or  
4 plan the same copayment amount or coinsurance rate that applies if those services  
5 are provided by a provider that is in the provider network of the policy or plan.

6           (d) The commissioner shall periodically update, by rule, the essential health  
7 benefits under this subsection to address any gaps in access to coverage.

8           (e) If an essential health benefit is also subject to mandated coverage elsewhere  
9 under this section and the coverage requirements are not identical, the disability  
10 insurance policy or self-insured health plan shall provide coverage under whichever  
11 subsection provides the insured or plan participant with more comprehensive  
12 coverage of the medical condition, item, or service.

13           (f) Nothing in this subsection or rules promulgated under this subsection  
14 prohibits a disability insurance policy or a self-insured health plan from providing  
15 benefits in excess of the essential health benefit coverage required under this  
16 subsection.

17           (g) This subsection does not apply to any disability insurance policy that is  
18 described in s. 632.745 (11) (b) 1. to 12.

19           **SECTION 35.** 632.895 (16m) (b) of the statutes is amended to read:

20           632.895 (16m) (b) The coverage required under this subsection may be subject  
21 to any limitations, or exclusions, or cost-sharing provisions that apply generally  
22 under the disability insurance policy or self-insured health plan. The coverage  
23 required under this subsection may not be subject to any deductibles, copayments,  
24 or coinsurance.

25           **SECTION 36.** 632.895 (17) (b) 2. of the statutes is amended to read:



1           632.895 (17) (b) 2. Outpatient consultations, examinations, procedures, and  
2 medical services that are necessary to prescribe, administer, maintain, or remove a  
3 contraceptive, ~~if covered for any other drug benefits under the policy or plan~~  
4 sterilization procedures, and patient education and counseling for all females with  
5 reproductive capacity.

6           **SECTION 37.** 632.895 (17) (c) of the statutes is amended to read:

7           632.895 (17) (c) Coverage under par. (b) may be subject only to the exclusions,  
8 and limitations, or cost-sharing provisions that apply generally to the coverage of  
9 outpatient health care services, preventive treatments and services, or prescription  
10 drugs and devices that is provided under the policy or self-insured health plan. A  
11 disability insurance policy or self-insured health plan may not apply a deductible or  
12 impose a copayment or coinsurance to at least one of each type of contraceptive  
13 method approved by the federal food and drug administration for which coverage is  
14 required under this subsection. The disability insurance policy or self-insured  
15 health plan may apply reasonable medical management to a method of contraception  
16 to limit coverage under this subsection that is provided without being subject to a  
17 deductible, copayment, or coinsurance to prescription drugs without a brand name.  
18 The disability insurance policy or self-insured health plan may apply a deductible  
19 or impose a copayment or coinsurance for coverage of a contraceptive that is  
20 prescribed for a medical need if the services for the medical need would otherwise be  
21 subject to a deductible, copayment, or coinsurance.

22           **SECTION 38.** 632.897 (11) (a) of the statutes is amended to read:

23           632.897 (11) (a) Notwithstanding subs. (2) to (10), the commissioner may  
24 promulgate rules establishing standards requiring insurers to provide continuation  
25 of coverage for any individual covered at any time under a group policy who is a

1 terminated insured or an eligible individual under any federal program that  
2 provides for a federal premium subsidy for individuals covered under continuation  
3 of coverage under a group policy, including rules governing election or extension of  
4 election periods, notice, rates, premiums, premium payment, application of  
5 ~~preexisting condition exclusions~~, election of alternative coverage, and status as an  
6 eligible individual, as defined in s. 149.10 (2t), 2011 stats.

7 **SECTION 9323. Initial applicability; Insurance.**

8 (1) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH  
9 BENEFITS, AND PREVENTIVE SERVICES.

10 (a) For policies and plans containing provisions inconsistent with these  
11 sections, the treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983  
12 (1) (intro.), 609.713, 609.847, 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a),  
13 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3.,  
14 (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1., 2., and 3., 632.795 (4)  
15 (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c) and (d) 3., (14m), (16m)  
16 (b), and (17) (b) 2. and (c), and 632.897 (11) (a) first applies to policy or plan years  
17 beginning on January 1 of the year following the year in which this paragraph takes  
18 effect, except as provided in par. (b).

19 (b) For policies and plans that are affected by a collective bargaining agreement  
20 containing provisions inconsistent with these sections, the treatment of ss. 40.51 (8)  
21 and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, 609.847, 625.12 (1)  
22 (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a),  
23 (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76  
24 (2) (a) and (ac) 1., 2., and 3., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and  
25 k. to o., (b), (c) and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11)

1 (a) first applies to policy or plan years beginning on the effective date of this  
2 paragraph or on the day on which the collective bargaining agreement is entered  
3 into, extended, modified, or renewed, whichever is later.

4 **SECTION 9423. Effective dates; Insurance.**

5 (1) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH  
6 BENEFITS, AND PREVENTIVE SERVICES. The treatment of ss. 40.51 (8) and (8m), 66.0137  
7 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, 609.847, 625.12 (1) (a) and (e) and (2),  
8 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3)  
9 (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1.,  
10 2., and 3., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c)  
11 and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) and SECTION  
12 9323 (1) of this act take effect on the first day of the 4th month beginning after  
13 publication.

14 (END)