250.10 **(1m)** (b) Award in each fiscal year to qualified applicants grants totaling ~~$25,000~~ no less than $50,000 for fluoride ~~supplements, $25,000 for a fluoride mouth-rinse program~~ varnish and other evidence-based oral health activities, $700,000 for school-based preventive dental services, and ~~$120,000 for a school-based dental sealant program~~ $100,000 for school-based restorative dental services.".

100. Page 433, line 12: delete the material beginning with that line and ending with page 434, line 2, and substitute:

"**SECTION 1893b.** 250.20 (3) of the statutes is amended to read:

250.20 **(3)** From the appropriation account under s. 20.435 (1) ~~(kb)~~ (cr), the department shall annually award grants for activities to improve the health status of economically disadvantaged minority group members. A person may apply, in the manner specified by the department, for a grant of up to $50,000 in each fiscal year to conduct these activities. An awardee of a grant under this subsection shall provide, for at least 50 percent of the grant amount, matching funds that may consist of funding or an in-kind contribution. An applicant that is not a federally qualified health center, as defined under 42 CFR 405.2401 (b) shall receive priority for grants awarded under this subsection. An applicant that provides maternal and child health services shall receive priority for grants awarded under this subsection.

SECTION 1894b. 250.20 (4) of the statutes is amended to read:

250.20 **(4)** From the appropriation account under s. 20.435 (1) ~~(kb)~~ (cr), the department shall award a grant of up to $50,000 in each fiscal year to a private nonprofit corporation that applies, in the manner specified by the department, to conduct a public information campaign on minority health.".

101. Page 434, line 3: delete the material beginning with that line and ending with page 445, line 17, and substitute:

"**SECTION 1896b.** 253.06 (1) (a) of the statutes is renumbered 253.06 (1) (am) and amended to read:

253.06 **(1)** (am) "~~Authorized~~ Approved food" means food identified by the department as an authorized food in accordance with 7 CFR 246.10 as acceptable for use under the federal special supplemental ~~food~~ nutrition program for women, infants and children under 42 USC 1786.

SECTION 1897b. 253.06 (1) (ag) of the statutes is created to read:

253.06 **(1)** (ag) "Alternate participant" means a person who has been authorized by a participant to request benefits, participate in nutrition education, bring an infant or child to a Women, Infants, and Children program appointment, and have access to information in the participant's file.

SECTION 1898b. 253.06 (1) (b) of the statutes is repealed.

SECTION 1899b. 253.06 (1) (br) of the statutes is created to read:

253.06 **(1)** (br) "Cardholder" means a participant; alternate participant; parent, legal guardian, or caretaker of a participant; or another person in possession of a Women, Infants, and Children program electronic benefit transfer card and the personal identification number for the card.

SECTION 1900b. 253.06 (1) (c) of the statutes is repealed.

SECTION 1901b. 253.06 (1) (cm) of the statutes is amended to read:

253.06 **(1)** (cm) "~~Food~~ Direct distribution center" means an entity, other than a vendor, that is under contract with the department under sub. (3m) to distribute ~~authorized~~ approved food to participants.

SECTION 1902b. 253.06 (1) (cp), (cr), (ct) and (cv) of the statutes are created to read:

253.06 **(1)** (cp) "Electronic benefit transfer" means a method that permits electronic access to Women, Infants, and Children program benefits using a device, approved by the department, with payments made in accordance with ch. 410.

(cr) "Food instrument" means a voucher, check, electronic benefit transfer card, electronic benefit transfer card number and personal identification number, coupon, or other method used by a participant to obtain Women, Infants, and Children program approved foods.

(ct) "Infant formula supplier" means a wholesaler, distributor, retailer, or manufacturer of infant formula.

(cv) "Local agency" means an entity that has a contract with the department to provide services under the Women, Infants, and Children program such as eligibility determination, benefit issuance, and nutritional counseling for participants.

SECTION 1903b. 253.06 (1) (dm) of the statutes is repealed.

SECTION 1904b. 253.06 (1) (dr) and (dv) of the statutes are created to read:

253.06 **(1)** (dr) "Summary suspension" means an emergency action taken by the department to suspend an authorization under the Women, Infants, and Children program.

(dv) "Trafficking" means doing any of the following:

1. Buying, selling, stealing, or otherwise exchanging for cash or consideration other than approved food Women, Infants, and Children program food instruments or benefits that are issued and accessed via a food instrument.

2. Exchanging firearms, ammunition, explosives, or controlled substances, as defined in 21 USC 802, for a food instrument.

3. Intentionally purchasing and reselling for cash or consideration other than approved food a product that is purchased with a food instrument.

4. Intentionally purchasing with cash or consideration other than approved food a product that was originally purchased with a food instrument.

SECTION 1905b. 253.06 (1) (e) of the statutes is amended to read:

253.06 **(1)** (e) "Vendor" means a ~~grocery store or pharmacy that sells authorized~~ person that operates one or more stores or pharmacies authorized by the department under sub. (3) to provide approved foods under a retail food delivery system.

SECTION 1906b. 253.06 (1) (f) of the statutes is repealed.

SECTION 1907b. 253.06 (1) (g) of the statutes is created to read:

253.06 **(1)** (g) "Women, Infants, and Children program" means the federal special supplemental nutrition program for women, infants and children under 42 USC 1786 and this section.

SECTION 1908b. 253.06 (1m) of the statutes is created to read:

253.06 **(1m)** PROGRAM ADMINISTRATION. (a) The department may identify an alternate participant as the Women, Infants, and Children program cardholder for purposes of electronic administration of the Women, Infants, and Children program.

SECTION 1909b. 253.06 (3) (a) (intro.) of the statutes is amended to read:

253.06 **(3)** (a) (intro.) The department may authorize a vendor ~~to accept drafts~~ only if the vendor meets all of the following conditions:

SECTION 1910b. 253.06 (3) (a) 5. of the statutes is created to read:

253.06 **(3)** (a) 5. The vendor has an electronic benefit transfer-capable cash register system or payment device, approved by the department, that is able to

accurately and securely obtain Women, Infants, and Children program food balances associated with the electronic benefit transfer card, maintain the necessary electronic files such as the approved food list, successfully complete Women, Infants, and Children program electronic benefit transfer purchases, and process Women, Infants, and Children program electronic benefit transfer payments.

SECTION 1911b. 253.06 (3) (bg) of the statutes is amended to read:

253.06 **(3)** (bg) The department may limit the number of vendors that it authorizes under this subsection if the department determines that the number of vendors already authorized under this subsection is sufficient to permit participants to obtain ~~authorized~~ approved food conveniently.

SECTION 1912b. 253.06 (3) (c) of the statutes is amended to read:

253.06 **(3)** (c) The department may ~~not~~ redeem ~~drafts~~ food instruments only when submitted by a person who is ~~not~~ an authorized vendor under this subsection except as provided in sub. (3m).

SECTION 1913b. 253.06 (3) (d) of the statutes is created to read:

253.06 **(3)** (d) Each store operated by a business entity is a separate vendor for purposes of this section and is required to have a single, fixed location, except when the authorization of mobile stores is necessary to meet special needs in accordance with 7 CFR 246.4 (1) (14) (xiv). The department shall require that each store be authorized as a vendor separately from other stores operated by the business entity.

SECTION 1914b. 253.06 (3m) (title) and (a) (intro.) of the statutes are amended to read:

253.06 **(3m)** (title) ~~FOOD~~ DIRECT DISTRIBUTION CENTERS. (a) (intro.) The department may contract for an alternative system of ~~authorized~~ approved food

distribution with an entity other than a vendor only if the entity meets all of the following requirements:

SECTION 1915b. 253.06 (3m) (a) 4. of the statutes is created to read:

253.06 **(3m)** (a) 4. The entity has an electronic benefit transfer-capable cash register system or payment device, approved by the department, that is able to accurately and securely obtain Women, Infants, and Children program food balances associated with the electronic benefit transfer card, maintain the necessary files, successfully complete Women, Infants, and Children program electronic benefit transfer purchases, and process Women, Infants, and Children program electronic benefit transfer payments.

SECTION 1916b. 253.06 (3m) (b) of the statutes is amended to read:

253.06 **(3m)** (b) The department ~~shall redeem valid drafts~~ may process a payment if submitted by a ~~food~~ direct distribution center that is authorized by the department under this subsection.

SECTION 1917b. 253.06 (4) (a) 1. of the statutes is amended to read:

253.06 **(4)** (a) 1. Accept ~~drafts or submit drafts~~ a food instrument or submit a request to the department for redemption without authorization.

SECTION 1918b. 253.06 (4) (a) 2. of the statutes is repealed.

SECTION 1919b. 253.06 (4) (a) 2m. of the statutes is created to read:

253.06 **(4)** (a) 2m. Engage in trafficking.

SECTION 1920b. 253.06 (4) (a) 3. to 4. of the statutes are amended to read:

253.06 **(4)** (a) 3. Accept a ~~draft~~ food instrument other than in exchange for ~~authorized~~ approved food that is ~~provided by the person~~ selected by the electronic benefit transfer cardholder.

3m. Provide ~~authorized~~ approved food or other commodities to ~~a participant or proxy~~ an electronic benefit transfer cardholder in exchange for a ~~draft~~ food instrument accepted by a 3rd party.

4. ~~Enter on a draft~~ Submit a payment request for a dollar amount that is higher than the actual retail price of the item for which ~~the draft~~ a food instrument was used.

SECTION 1921b. 253.06 (4) (a) 5. of the statutes is repealed.

SECTION 1922b. 253.06 (4) (a) 5m. of the statutes is created to read:

253.06 **(4)** (a) 5m. Confiscate a food instrument or ask for or enter the electronic benefit transfer cardholder's personal identification number.

SECTION 1923b. 253.06 (4) (a) 6. and 8. of the statutes are repealed.

SECTION 1924b. 253.06 (4) (a) 9. of the statutes is amended to read:

253.06 **(4)** (a) 9. ~~Submit for redemption a draft~~ Provide to someone other than the department a food instrument; a Women, Infants, and Children program electronic benefit transfer card; or food purchased with a food instrument for something of value.

SECTION 1925b. 253.06 (4) (a) 10. of the statutes is repealed.

SECTION 1926b. 253.06 (5) (a) 1. and 2. of the statutes are amended to read:

253.06 **(5)** (a) 1. Minimum qualification standards for the authorization of vendors and infant formula suppliers and for the awarding of a contract to an entity under sub. (3m).

2. Standards of operation for authorized vendors and infant formula suppliers and ~~food~~ direct distribution centers, including prohibited practices.

SECTION 1927b. 253.06 (5) (b) 1. to 3. of the statutes are amended to read:

253.06 **(5)** (b) 1. Denial of the application to be a participant or authorized vendor or infant formula supplier.

2. ~~Suspension~~ Summary suspension or termination of authorization for an authorized vendor or infant formula supplier or, in the case of a ~~food~~ direct distribution center, termination of the contract.

3. Disqualification from the program under this section for a vendor, infant formula supplier, or participant.

SECTION 1928b. 253.06 (5) (b) 6. to 8. of the statutes are created to read:

253.06 **(5)** (b) 6. Civil monetary penalty.

7. Warning letter.

8. Implementation of a corrective action plan.

SECTION 1929b. 253.06 (5) (d) (intro.) and 6. of the statutes are amended to read:

253.06 **(5)** (d) (intro.) The department may directly assess a forfeiture provided for under par. (b) 4., recoupment provided for under par. (b) 5. and an enforcement assessment provided for under par. (c). If the department determines that a forfeiture, recoupment or enforcement assessment should be levied, or that authorization or eligibility should be summarily suspended or terminated, for a particular violation or for failure to correct it, the department shall send a notice of assessment, summary suspension or termination to the vendor, ~~food~~ infant formula supplier, direct distribution center or participant. The notice shall inform the vendor, ~~food~~ infant formula supplier, direct distribution center or participant of the right to a hearing under sub. (6) and shall specify all of the following:

6. If applicable, ~~that~~ the ~~suspension or termination of authorization of the vendor or eligibility of the participant is~~ effective ~~beginning on the 15th day after receipt~~ date of the ~~notice of~~ summary suspension or termination.

SECTION 1930b. 253.06 (5) (e) of the statutes is renumbered 253.06 (5) (e) 1. and amended to read:

253.06 **(5)** (e) 1. The ~~suspension or~~ termination of authorization of a vendor, infant formula supplier, or direct distribution center or eligibility of a participant shall be effective beginning on the 15th day after receipt of the notice of ~~suspension or~~ termination.

2. All forfeitures, recoupments, and enforcement assessments shall be paid to the department within 15 days after receipt of notice of assessment or, if the forfeiture, recoupment, or enforcement assessment is contested under sub. (6), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is adverse to the department or unless the final decision is appealed and the decision is stayed by court order under sub. (7). The department shall remit all forfeitures paid to the secretary of administration for deposit in the school fund. The department shall deposit all enforcement assessments in the appropriation under s. 20.435 (1) (gr).

SECTION 1931b. 253.06 (5) (e) 3. of the statutes is created to read:

253.06 **(5)** (e) 3. The summary suspension of authorization of a vendor, infant formula supplier, or direct distribution center shall be effective immediately upon receipt of the notice under par. (d).

SECTION 1932b. 253.06 (6) (b) of the statutes is amended to read:

253.06 **(6)** (b) A person may contest an assessment of forfeiture, recoupment or enforcement assessment, a denial, ~~suspension~~ or termination of authorization, a civil monetary penalty assessed in lieu of disqualification, a summary suspension, or a ~~suspension or~~ termination of eligibility by sending a written request for hearing under s. 227.44 to the division of hearings and appeals in the department of

administration within 10 days after the receipt of the notice issued under sub. (3) (bm) or (5) (d). The administrator of the division of hearings and appeals may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator of the division of hearings and appeals shall be the final administrative decision. The division of hearings and appeals shall commence the hearing and issue a final decision within 60 days after receipt of the request for hearing unless all of the parties consent to a later date. Proceedings before the division of hearings and appeals are governed by ch. 227. In any petition for judicial review of a decision by the division of hearings and appeals, the department, if not the petitioner who was in the proceeding before the division of hearings and appeals, shall be the named respondent.

SECTION 1933b. 253.06 (8) of the statutes is amended to read:

253.06 **(8)** INSPECTION OF PREMISES. The department may visit and inspect each authorized vendor and infant formula supplier and each ~~food~~ direct distribution center, and for such purpose shall be given unrestricted access to the premises described in the authorization or contract.

SECTION 1934b. 253.06 (9) and (10) of the statutes are created to read:

253.06 **(9)** CONFIDENTIALITY OF APPLICANT AND PARTICIPANT INFORMATION. (a) Any information about an applicant or participant, whether it is obtained from the applicant or participant or another source or is generated as a result of application for the Women, Infants, and Children program, that identifies the applicant or participant or a family member of the applicant or participant is confidential.

(b) Except as explicitly permitted under this section, the department shall restrict the use and disclosure of confidential applicant and participant information to any person directly connected with the administration or enforcement of the

Women, Infants, and Children program that the department determines has a need to know the information for Women, Infants, and Children program purposes. Persons who may be allowed to access confidential information under this paragraph include personnel from the local agencies, persons under contract with the department to perform research regarding the Women, Infants, and Children program, and persons that are investigating or prosecuting Women, Infants, and Children program violations of federal, state, or local law.

(c) The department or any local agency may use or disclose to public organizations confidential applicant and participant information for the administration of other programs that serve individuals eligible for the Women, Infants, and Children program in accordance with 7 CFR 246.26 (h).

(d) Staff of the department and local agencies who are required by state law to report known or suspected child abuse or neglect may disclose confidential applicant and participant information without the consent of the participant or applicant to the extent necessary to comply with the law.

(e) Except in the case of subpoenas or search warrants, the department and local agencies may disclose confidential applicant and participant information to individuals or entities not listed in this section only if the affected applicant or participant signs a release form authorizing the disclosure and specifying the parties to which the information may be disclosed. The department or local agency shall allow applicants and participants to refuse to sign the release form and shall notify the applicant or participant that signing the form is not a condition of eligibility and refusing to sign the form will not affect the applicant's or participant's application or participation in the Women, Infants, and Children program. Release forms authorizing disclosure to private physicians or other health care providers may be

included as part of the Women, Infants, and Children program application or certification process. All other requests for applicants or participants to sign voluntary release forms may occur only after the application and certification process is complete.

(f) The department or local agency shall provide to an applicant or participant access to all information he or she has provided to the Women, Infants, and Children program. In the case of an applicant or participant who is an infant or child, the access may be provided to a parent or guardian of the infant or child, assuming that any issues regarding custody or guardianship have been settled. The department or local agency is not required to provide the applicant or participant or parent or guardian of an infant or child applicant or participant access to any other information in the file or record, including documentation of income provided by a 3rd party and staff assessments of an applicant or participant's condition or behavior, unless required by law or unless the information supports a state or local agency decision being appealed under 7 CFR 246.9.

(10) CONFIDENTIALITY OF VENDOR INFORMATION. (a) Any information about a vendor, whether it is obtained from the vendor or another source, that individually identifies the vendor except for the vendor's name, address, telephone number, Internet or electronic mail address, store type, and Women, Infants, and Children program authorization status is confidential. The department shall restrict the use or disclosure of confidential vendor information to any of the following:

1. Persons directly connected with the administration or enforcement of the Women, Infants, and Children program or the food stamp program under s. 49.79 that the department determines has a need to know the information for purposes of these programs. These persons may include personnel from local agencies and

persons investigating or prosecuting violations of Women, Infants, and Children program or food stamp program federal, state, or local laws.

2. Persons directly connected with the administration or enforcement of any federal or state law or local ordinance. Before releasing information to a state or local entity, the department shall enter into a written agreement with the requesting party specifying that the information may not be used or redisclosed except for purposes directly connected with the administration or enforcement of the federal or state law or local ordinance.

3. A vendor that is subject to an adverse action under sub. (5), including a claim, to the extent that the confidential information concerns the vendor that is subject to the adverse action and is related to the adverse action.

(b) The department may disclose to all authorized vendors and applicants to be a vendor sanctions that have been imposed on vendors if the disclosure identifies only the vendor's name, address, length of the disqualification or amount of the monetary penalty, and a summary of the reason for the sanction provided in the notice of adverse action under sub. (5). The information under this paragraph may be disclosed only after all administrative and judicial review is exhausted and the department has prevailed regarding the sanction imposed on the vendor or after the time period for requesting administrative and judicial review has expired.".

102. Page 445, line 17: after that line insert:

"**SECTION 1935w.** 253.07 (1) (a) 3. of the statutes is created to read:

253.07 **(1)** (a) 3. Pregnancy termination.

SECTION 1936w. 253.07 (1) (b) 3. of the statutes is created to read:

253.07 **(1)** (b) 3. Pregnancy termination.

SECTION 1937w. 253.07 (5) (b) (intro.) of the statutes is renumbered 253.07 (5) (b) and amended to read:

253.07 **(5)** (b) ~~Subject to par. (c), a~~ A public entity that receives women's health funds under this section may provide some or all of the funds to other public or private entities ~~provided that the recipient of the funds does not do any of the following:~~.

SECTION 1938w. 253.07 (5) (b) 1. to 3. of the statutes are repealed.

SECTION 1939w. 253.07 (5) (c) of the statutes is repealed.

SECTION 1940w. 253.075 of the statutes is repealed.".

103. Page 446, line 1: delete lines 1 to 2 and substitute:

"254.151 **(2m)** Award grants for residential lead hazard abatement, residential lead hazard reduction, and lead abatement worker training.".

104. Page 448, line 25: delete the material beginning with that line and ending with page 449, line 2, and substitute:

"**SECTION 1950m.** 255.06 (2) (i) of the statutes is amended to read:

255.06 **(2)** (i) *Multiple sclerosis services.* Allocate and expend ~~at least~~ up to $60,000 as reimbursement for the provision of multiple sclerosis services to women.".

105. Page 454, line 2: after that line insert:

"**SECTION 2069f.** 601.83 (1) (a) of the statutes is amended to read:

601.83 **(1)** (a) The commissioner shall administer a state-based reinsurance program known as the healthcare stability plan in accordance with the specific terms and conditions approved by the federal department of health and human services dated July 29, 2018. Before December 31, 2023, the commissioner may not request from the federal department of health and human services a modification,

suspension, withdrawal, or termination of the waiver under 42 USC 18052 under which the healthcare stability plan under this subchapter operates unless legislation has been enacted specifically directing the modification, suspension, withdrawal, or termination. Before December 31, 2023, the commissioner may request renewal, without substantive change, of the waiver under 42 USC 18052 under which the health care stability plan operates ~~in accordance with s. 20.940 (4)~~ unless legislation has been enacted that is contrary to such a renewal request. ~~The commissioner shall comply with applicable timing in and requirements of s. 20.940.~~".

SECTION 2070i. 609.713 of the statutes is created to read:

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

SECTION 2071i. 609.847 of the statutes is created to read:

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

SECTION 2072i. 625.12 (1) (a) of the statutes is amended to read:

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

SECTION 2073i. 625.12 (1) (e) of the statutes is amended to read:

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

SECTION 2074i. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. ~~Risks~~ Except as provided in s. 632.728, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classifications may be based on race, color, creed or

national origin, and classifications in automobile insurance may not be based on physical condition or developmental disability as defined in s. 51.01 (5). Subject to ~~s.~~ ss. 632.365 and 632.728, rates thus produced may be modified for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards, expenses, or both. Rates may also be modified for individual risks under s. 625.13 (2).

SECTION 2075i. 625.15 (1) of the statutes is amended to read:

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

SECTION 2076i. 628.34 (3) (a) of the statutes is amended to read:

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

106. Page 454, line 12: after that line insert:

"SECTION **2079i.** 632.728 of the statutes is created to read:

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

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

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

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

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

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

1. Health status.

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

3. Claims experience.

4. Receipt of health care.

5. Medical history.

6. Genetic information.

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

8. Disability.

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

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

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

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

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

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

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

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

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

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

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

SECTION 2080i. 632.746 (1) (a) of the statutes is renumbered 632.746 (1) and amended to read:

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

SECTION 2081i. 632.746 (1) (b) of the statutes is repealed.

SECTION 2082i. 632.746 (2) (a) of the statutes is amended to read:

632.746 **(2)** (a) An insurer offering a group health benefit plan may not ~~treat~~ impose a preexisting condition exclusion based on genetic information~~ as a~~

~~preexisting condition under sub. (1) without a diagnosis of a condition related to the information~~.

SECTION 2083i. 632.746 (2) (c), (d) and (e) of the statutes are repealed.

SECTION 2084i. 632.746 (3) (a) of the statutes is repealed.

SECTION 2085i. 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

SECTION 2086i. 632.746 (3) (d) 2. and 3. of the statutes are repealed.

SECTION 2087i. 632.746 (5) of the statutes is repealed.

SECTION 2088i. 632.746 (8) (a) (intro.) of the statutes is amended to read:

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

SECTION 2089i. 632.748 (2) of the statutes is amended to read:

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

SECTION 2090i. 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the

condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a group health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance policy, as defined in s. 632.895 (1) (a), or a self-insured health plan, as defined in s. 632.85 (1) (c).

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

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

SECTION 2091i. 632.76 (2) (ac) 3. of the statutes is repealed.

SECTION 2092i. 632.795 (4) (a) of the statutes is amended to read:

632.795 **(4)** (a) An insurer subject to sub. (2) shall provide coverage under the same policy form and for the same premium as it originally offered in the most recent enrollment period, subject only to the medical underwriting used in that enrollment period. Unless otherwise prescribed by rule, the insurer may apply deductibles, ~~preexisting condition limitations,~~ waiting periods, or other limits only to the extent

that they would have been applicable had coverage been extended at the time of the most recent enrollment period and with credit for the satisfaction or partial satisfaction of similar provisions under the liquidated insurer's policy or plan. The insurer may exclude coverage of claims that are payable by a solvent insurer under insolvency coverage required by the commissioner or by the insurance regulator of another jurisdiction. Coverage shall be effective on the date that the liquidated insurer's coverage terminates.

SECTION 2093k. 632.796 of the statutes is created to read:

632.796 Drug cost report. (1) DEFINITION. In this section, "disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(2) REPORT REQUIRED. Annually, at the time the insurer files its rate request with the commissioner, each insurer that offers a disability insurance policy that covers prescription drugs shall submit to the commissioner a report that identifies the 25 prescription drugs that are the highest cost to the insurer and the 25 prescription drugs that have the highest cost increases over the 12 months before the submission of the report.

SECTION 2094k. 632.865 (3) of the statutes is created to read:

632.865 **(3)** REGISTRATION REQUIRED. (a) No person may perform any activities of a pharmacy benefit manager in this state without first registering with the commissioner under this subsection.

(b) The commissioner shall establish a registration procedure for pharmacy benefit managers. The commissioner may promulgate any rules necessary to implement the registration procedure under this paragraph.

SECTION 2095k. 632.866 of the statutes is created to read:

632.866 Prescription drug cost reporting. (1) DEFINITIONS. In this section:

(a) "Brand-name drug" means a prescription drug approved under 21 USC 355 (b) or 42 USC 262.

(b) "Covered hospital" means an entity described in 42 USC 256b (a) (4) (L) to (N) that participates in the federal drug-pricing program under 42 USC 256b.

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

(d) "Generic drug" means a prescription drug approved under 21 USC 355 (j).

(e) "Manufacturer" has the meaning given in s. 450.01 (12). "Manufacturer" does not include an entity that is engaged only in the dispensing, as defined in s. 450.01 (7), of a brand-name drug or a generic drug.

(f) "Manufacturer-sponsored assistance program" means a program offered by a manufacturer or an intermediary under contract with a manufacturer through which a brand-name drug or a generic drug is provided to a patient at no charge or at a discount.

(g) "Margin" means, for a covered hospital, the difference between the net cost of a brand-name drug or generic drug covered under the federal drug-pricing program under 42 USC 256b and the net payment by the covered hospital for that brand-name drug or generic drug.

(h) "Net payment" means the amount paid for a brand-name drug or generic drug after all discounts and rebates have been applied.

(i) "Pharmacy benefit manager" has the meaning given in s. 632.865 (1) (c).

(j) "Wholesale acquisition cost" means the most recently reported manufacturer list or catalog price for a brand-name drug or a generic drug available to wholesalers or direct purchasers in the United States, before application of discounts, rebates, or reductions in price.

(2) PRICE INCREASE OR INTRODUCTION NOTICE; JUSTIFICATION REPORT. (a) A manufacturer shall notify the commissioner if it is increasing the wholesale acquisition cost of a brand-name drug on the market in this state by more than 10 percent or by more than $10,000 during any 12-month period or if it intends to introduce to market in this state a brand-name drug that has an annual wholesale acquisition cost of $30,000 or more.

(b) A manufacturer shall notify the commissioner if it is increasing the wholesale acquisition cost of a generic drug by more than 25 percent or by more than $300 during any 12-month period or if it intends to introduce to market a generic drug that has an annual wholesale acquisition cost of $3,000 or more.

(c) The manufacturer shall provide the notice under par. (a) or (b) in writing at least 30 days before the planned effective date of the cost increase or drug introduction with a justification that includes all documents and research related to the manufacturer's selection of the cost increase or introduction price and a description of life cycle management, market competition and context, and estimated value or cost-effectiveness of the product.

(3) NET PRICES PAID BY PHARMACY BENEFIT MANAGERS. By March 1 annually, the manufacturer shall report to the commissioner the value of price concessions, expressed as a percentage of the wholesale acquisition cost, provided to each pharmacy benefit manager for each drug sold in this state.

(4) REBATES AND PRICE CONCESSIONS. By March 1 annually, each pharmacy benefit manager shall report to the commissioner the amount received from manufacturers as drug rebates and the value of price concessions, expressed as a percentage of the wholesale acquisition cost, provided by manufacturers for each drug.

(5) HOSPITAL MARGIN SPENDING. By March 1 annually, each covered hospital operating in this state shall report to the commissioner the per unit margin for each drug covered under the federal drug pricing program under 42 USC 256b dispensed in the previous year multiplied by the number of units dispensed at that margin and how the margin revenue was used.

(6) MANUFACTURER-SPONSORED ASSISTANCE PROGRAMS. By March 1 annually, each manufacturer shall provide the commissioner with a description of each manufacturer-sponsored patient assistance program in effect during the previous year that includes all of the following:

(a) The terms of the programs.

(b) The number of prescriptions provided to state residents under the program.

(c) The total market value of assistance provided to residents of this state under the program.

(7) CERTIFICATION AND PENALTIES FOR NONCOMPLIANCE. Each manufacturer and covered hospital that is required to report under this section shall certify each report as accurate under the penalty of perjury. A manufacturer or covered hospital that fails to submit a report required under this section is subject to a forfeiture of no more than $10,000 each day the report is overdue.

(8) HEARING AND PUBLIC REPORTING. (a) The commissioner shall publicly post manufacturer price justification documents and covered hospital documentation of how each hospital spends the margin revenue. The commissioner shall keep any trade secret or proprietary information confidential.

(b) The commissioner shall analyze data collected under this section and publish annually a report on emerging trends in prescription prices and price increases, and shall annually conduct a public hearing based on the analysis under

this paragraph. The report under this paragraph shall include analysis of manufacturer prices and price increases, analysis of hospital-specific margins and how that revenue is spent or allocated on a hospital-specific basis, and analysis of how pharmacy benefit manager discounts and net costs compare to retail prices paid by patients.

(9) ALLOWING COST DISCLOSURE TO INSURED. The commissioner shall ensure that every disability insurance policy that covers prescription drugs or biological products does not restrict a pharmacy or pharmacist that dispenses a prescription drug or biological product from informing and does not penalize a pharmacy or pharmacist for informing an insured under a policy of a difference between the negotiated price of, or copayment or coinsurance for, the drug or biological product under the policy and the price the insured would pay for the drug or biological product if the insured obtained the drug or biological product without using any health insurance coverage.

SECTION 2097i. 632.895 (8) (d) of the statutes is amended to read:

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

SECTION 2098i. 632.895 (13m) of the statutes is created to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24. Gonorrhea prophylaxis treatment for newborns.

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

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

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

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

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

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

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

32. Screening for critical congenital health defects for newborns.

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

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

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

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

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

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

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

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

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

42. Developmental screening and surveillance for minors including newborns.

43. Psychosocial and behavioral assessment for minors including newborns.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2099i. 632.895 (14) (a) 1. i. and j. of the statutes are amended to read:

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

j. Varicella and herpes zoster.

SECTION 2100i. 632.895 (14) (a) 1. k. to o. of the statutes are created to read:

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

L. Meningococcal meningitis.

m. Pneumococcal pneumonia.

n. Influenza.

o. Rotavirus.

SECTION 2101i. 632.895 (14) (b) of the statutes is amended to read:

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

SECTION 2102i. 632.895 (14) (c) of the statutes is amended to read:

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

SECTION 2103i. 632.895 (14) (d) 3. of the statutes is amended to read:

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

SECTION 2104i. 632.895 (14m) of the statutes is created to read:

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

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

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

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

a. Ambulatory patient services.

b. Emergency services.

c. Hospitalization.

d. Maternity and newborn care.

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

f. Prescription drugs.

g. Rehabilitative and habilitative services and devices.

h. Laboratory services.

i. Preventive and wellness services and chronic disease management.

j. Pediatric services, including oral and vision care.

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2105i. 632.895 (16m) (b) of the statutes is amended to read:

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

SECTION 2106i. 632.895 (17) (b) 2. of the statutes is amended to read:

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

SECTION 2107i. 632.895 (17) (c) of the statutes is amended to read:

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

SECTION 2108i. 632.897 (11) (a) of the statutes is amended to read:

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

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

107. Page 455, line 18: after that line insert:

"**SECTION 2118m.** 767.805 (4) (d) of the statutes is repealed.

SECTION 2119m. 767.89 (3) (e) of the statutes is repealed.".

108. Page 460, line 2: after that line insert:

"**SECTION 2264g.** 2017 Wisconsin Act 370, Section 44 (2) and (3) are repealed.".

109. Page 488, line 8: after that line insert:

"(1) PRESCRIPTION DRUG POOLING STUDY. The department of employee trust funds, in consultation with the department of corrections, the department of health services, and the department of veterans affairs, shall study the options and opportunities for cost savings to state agencies through prescription drug pooling. No later than January 1, 2020, the department of employee trust funds shall submit a report of the study to the governor and the appropriate standing committees of the legislature, as determined by the speaker of the assembly and the president of the senate, in the manner provided under s. 13.172 (3).".

110. Page 488, line 16: after that line insert:

"(1s) FORENSIC UNIT EXPANSION AT SAND RIDGE SECURE TREATMENT CENTER. From the appropriation under s. 20.435 (2) (bm), the department of health services shall allocate $3,430,900 in fiscal year 2020-21 and create 36.50 FTE GPR positions to

operate a 20-bed unit for forensic patients at the Sand Ridge Secure Treatment Center.

(1t) YOUTH CRISIS STABILIZATION FACILITIES AND PEER-RUN RESPITE CENTERS FOR VETERANS. The department of health services shall award in each fiscal year $996,400 in grants to youth crisis stabilization facilities and $450,000 in grants to a peer-run respite center for veterans.".

111. Page 488, line 17: delete the material beginning with that line and ending with page 489, line 3, and substitute:

"(2b) MEDICAL ASSISTANCE REIMBURSEMENT FOR SERVICES PROVIDED THROUGH TELEHEALTH. The department of health services shall develop, by rule, a method of reimbursing providers under the Medical Assistance program for a service that is covered by the Medical Assistance program under subch. IV of ch. 49 and that satisfies any of the following:

(a) The service is a consultation between a provider at an originating site and a provider at a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment.

(b) The service is an asynchronous transmission of digital clinical information through a secure electronic system from a Medical Assistance recipient or provider to a provider.".

112. Page 489, line 3: after that line insert:

"(2g) CHILDLESS ADULTS DEMONSTRATION PROJECT REFORM WAIVER. The department of health services may submit a request to the federal department of health and human services to modify or withdraw the waiver granted under s. 49.45 (23) (g), 2017 stats.

(3g) ACADEMIC DETAILING TRAINING PROGRAM.

(a) In this subsection, "academic detailing" means a teaching model under which health care experts are taught techniques for engaging in interactional educational outreach to other health care providers and clinical staff to provide information on evidence-based practices and successful therapeutic interventions with the goal of improving patient care.

(b) The department of health services shall establish and implement a 2-year academic detailing primary care clinic dementia training program in 10 primary care clinics in the state through a contract with the Wisconsin Alzheimer's Institute.

(c) The department shall, as part of the training program, provide primary care providers with clinical training and access to educational resources on best practices for diagnosis and management of common cognitive disorders, and referral strategies to dementia specialists for complicated or rare cognitive or behavioral disorders.

(d) The department shall ensure that the training program under this subsection includes at least the following three components:

1. The most current research on effective clinical treatments and practices is systematically evaluated by the academic detailing team.

2. Information gathered and evaluated under subd. 1. is packaged into an easily accessible format that is clinically relevant, rigorously sourced, and compellingly formatted.

3. Training is provided for clinicians to serve as academic detailers that equips them with clinical expertise and proficiency in conducting an interactive educational exchange to facilitate individualized learning among participating primary care practitioners in the target clinics.".

113. Page 489, line 14: after that line insert:

"(4c) CHILDLESS ADULTS DEMONSTRATION PROJECT. The department of health services shall submit any necessary request to the federal department of health and human services for a state plan amendment or waiver of federal Medicaid law or to modify or withdraw from any waiver of federal Medicaid law relating to the childless adults demonstration project under s. 49.45 (23), 2017 stats., to reflect the incorporation of recipients of Medical Assistance under the demonstration project into the BadgerCare Plus program under s. 49.471 and the termination of the demonstration project.".

114. Page 489, line 15: delete lines 15 to 20 and substitute:

"(6b) EVIDENCE-BASED ORAL HEALTH GRANTS AND SEAL-A-SMILE PROGRAM. Notwithstanding s. 250.10 (1m) (b), in fiscal year 2019-20, the department of health services shall, from the appropriation under s. 20.435 (1) (de), award to qualified applicants grants totaling $50,000 for fluoride varnish and other evidence-based oral health activities, $525,000 for school-based preventive dental services, and $100,000 for school-based restorative dental services.".

115. Page 489, line 20: after that line insert:

"(6d) PRESCRIPTION DRUG IMPORTATION PROGRAM. The department of health services shall submit the first report required under s. 250.048 (5) by the next January 1 or July 1, whichever is earliest, that is at least 180 days after the date the prescription drug importation program is fully operational under s. 250.048 (4). The department of health services shall include in the first 3 reports submitted under s. 250.048 (5) information on the implementation of the audit functions under s. 250.048 (1) (n).".

116. Page 490, line 5: after that line insert:

"(8m) COMMUNITY-BASED DOULAS. From the appropriation under s. 20.435 (4) (bm), the department of health services shall in fiscal year 2019-20 allocate $192,000 to public or private entities, American Indian tribes or tribal organizations, or community-based organizations for grants for community-based doulas. The recipients of the grants shall use the moneys to identify and train local community workers to mentor pregnant women.".

117. Page 490, line 6: delete lines 6 to 11 and substitute:

"(9b) DENTAL SERVICES UNDER MEDICAL ASSISTANCE. During the 2019-21 fiscal biennium, the department of health services shall allocate a total of $2,000,000 in the 2019-20 fiscal year and $3,000,000 in the 2020-21 fiscal year from all funding sources to increase reimbursement rates for dental services that are covered under the Medical Assistance program under subch. IV of ch. 49 and that are provided to recipients of Medical Assistance who have disabilities.".

118. Page 490, line 11: after that line insert:

"(9r) WISCONSIN CHRONIC DISEASE PROGRAM. In fiscal year 2019-20, the department of health services shall allocate $3,782,200 from the appropriation under s. 20.435 (4) (e) and $983,500 from the appropriation under s. 20.435 (4) (je) to fund the Wisconsin Chronic Disease Program as provided under ss. 49.68, 49.683, and 49.685. In fiscal year 2020-21, the department of health services shall allocate $3,939,300 from the appropriation under s. 20.435 (4) (e) and $1,027,300 from the appropriation under s. 20.435 (4) (je) to fund the Wisconsin Chronic Disease Program as provided under ss. 49.68, 49.683, and 49.685.".

119. Page 490, line 12: delete lines 12 to 16 and substitute:

"(10c) INFANT MORTALITY PREVENTION PROGRAM. The department of health services shall allocate 5.0 FTE positions that are authorized for the department of health services to staff an infant mortality prevention program. The department of health services shall report in its 2021-23 budget request any necessary budget adjustments to reflect this allocation of positions.".

120. Page 490, line 16: after that line insert:

"(10d) DISPATCHER ASSISTED CARDIOPULMONARY RESUSCITATION. Beginning in fiscal year 2019-20, the department of health services shall allocate $105,900 each fiscal year to assist public safety answering points in complying with dispatcher training requirements on telephonic assistance on administering cardiopulmonary resuscitation enacted in 2017 Wisconsin Act 296, including $75,900 under 20.435 (1) (cj) for the department of health services to distribute, either as grants to public safety answering points or by contracting with an entity to provide training to public safety answering points, and $30,000 to fund supplies and services for the program under the department of health services general program operations appropriation under s. 20.435 (1) (a).".

121. Page 491, line 3: delete lines 3 to 15.

122. Page 491, line 15: after that line insert:

"(10s) ONE-TIME FUNDING FOR INFORMATION TECHNOLOGY INFRASTRUCTURE IMPROVEMENTS. In fiscal year 2019-20, the department of health services shall allocate $500,000 on a one-time basis to fund information technology infrastructure improvements as part of an automated licensing project and to enable assisted living providers to enter reports online.".

$15,000,000, as the state share of payments, and the matching federal share of payments in each of fiscal years 2019-20 and 2020-21

123. Page 491, line 20: delete the material beginning with "facilities;" and ending with "2020-21" on line 23 and substitute " facilities and an additional 1.5 percent annual rate increase".

124. Page 492, line 1: delete lines 1 to 7 and substitute:

"(12b) MEDICAL ASSISTANCE REIMBURSEMENT RATE INCREASE FOR DIRECT CARE IN PERSONAL CARE AGENCIES. The department of health services shall increase the Medical Assistance rates paid for direct care to agencies that provide personal care services 1.5 percent annually to support staff in those agencies who perform direct care.". by $15,300,000, as the state share of payments, and the matching federal share of payments in fiscal year 2019-20 and $21,600,000, as the state share of payments and the matching federal share of payments in fiscal year 2020-21

125. Page 492, line 7: after that line insert:

"(13) LEAD EXPOSURE AND POISONING PREVENTION STAFF. The authorized FTE positions for the department of health services are increased by 1.0 GPR project position for the period ending June 30, 2021, and 1.14 GPR positions beginning on July 1, 2019, to be funded from the appropriation under s. 20.435 (1) (a), for the purpose of administering the department's lead public health outreach initiative and for enhancing the department's lead poisoning prevention programs.".

126. Page 492, line 18: after that line insert:

"(1k) PRESCRIPTION DRUG COST SURVEY. The commissioner of insurance shall conduct a statistically valid survey of pharmacies in this state regarding whether the pharmacy agreed to not disclose that customer drug benefit cost sharing exceeds the cost of the dispensed drug.

(2k) PRESCRIPTION DRUG COST REPORTING POSITIONS. The authorized FTE positions for the office of the commissioner of insurance are increased by 2.0 PR positions, to be funded from the appropriation under s. 20.145 (1) (g), for the purpose

of administering prescription drug cost reporting and registration of pharmacy benefit managers under ss. 632.796, 632.865 (3), and 632.866.".

127. Page 501, line 11: delete lines 11 to 20.

128. Page 505, line 11: after that line insert:

"(2m) ELIMINATION OF BIRTH COST RECOVERY. The treatment of ss. 49.45 (19) (a) and (c), 49.855 (3) (with respect to the elimination of statutory reference to court authority to issue new orders for birth expenses) and (4m) (b), 767.805 (4) (d), and 767.89 (3) (e) first applies to an order or judgment relating to paternity issued on the effective date of this subsection.".

129. Page 505, line 16: after that line insert:

"(1i) 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) and (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), (13m), (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 paragraph takes effect, except as provided in par. (b).

(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) and (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), (13m), (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 paragraph or on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.".

130. Page 509, line 1: after that line insert:

"(1c) MEDICAID EXPANSION. The treatment of ss. 20.435 (4) (jw) and 49.45 (23) takes effect on January 1, 2020.".

131. Page 509, line 6: after that line insert:

"(1i) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES. The treatment of ss. 40.51 (8) and (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), (13m), (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) and SECTION 9323 (1i) of this act take effect on the first day of the 4th month beginning after publication.".

(END)

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