State of Wisconsin
2025 - 2026 LEGISLATURE

LRB-0814/P4
KMS&JPC:all

DOA:.....Sherwin, BB0037 - Health Insurance Mandates

FOR 2025-2027 BUDGET -- NOT READY FOR INTRODUCTION

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

Analysis by the Legislative Reference Bureau

INSURANCE

Coverage of infertility services

This bill requires health insurance policies and self-insured governmental health plans that cover medical or hospital expenses to cover diagnosis of and treatment for infertility and standard fertility preservation services. Coverage required under the bill must include at least four completed egg retrievals with unlimited embryo transfers, in accordance with certain guidelines, and single embryo transfer when recommended and medically appropriate. Policies and plans may not impose an exclusion, limitation, or other restriction on the coverage required under the bill on the basis that an insured person participates in fertility services provided by or to a third party. Policies and plans are also prohibited from imposing an exclusion, limitation, or other restriction on coverage of medications for which the bill requires coverage that is not imposed on any other prescription medications covered under the policy or plan. Similarly, policies and plans may not impose any exclusion, limitation, cost-sharing requirement, benefit maximum, waiting period, or other restriction on diagnosis, treatment, or services for which coverage is required under the bill that is different from any exclusion, limitation, cost-sharing requirement, benefit maximum, waiting period, or other restriction imposed on benefits for other services. The bill refers to health insurance policies as disability insurance policies.

Coverage of individuals with preexisting conditions and other insurance market regulations

The 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 health status-related factors; prohibits plans from setting lifetime or annual limits on benefits; requires plans to cover certain essential health benefits; requires coverage of certain preventive services by plans without a cost-sharing contribution by an enrollee; sets a maximum annual amount of cost sharing for enrollees; and designates risk pool, medical loss ratio, and actuarial value requirements.

The bill requires every individual health insurance policy, referred to in the

bill as health benefit plans, to accept every individual who, and every group health insurance policy to accept every employer that, applies for coverage, regardless of the sexual orientation, the gender identity, or any preexisting condition of any individual or employee who will be covered by the plan. 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 that is 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 an otherwise 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 bill specifies a maximum amount of cost sharing that a plan may impose as the amount calculated under the federal Patient Protection and Affordable Care Act (ACA).

The bill requires individual and small employer plans to have either a single statewide risk pool for the individual market and a single pool for the small employer market or a single statewide risk pool for a combination of the individual and small employer markets. The bill requires individual and small employer plans to have a medical loss ratio of at least 80 percent and larger group plans to have a medical loss ratio of at least 85 percent. The medical loss ratio is the proportion of premium revenues that the plan spends on clinical services and quality improvement. The bill also requires individual and small employer plans to provide a level of coverage that is designed to provide benefits that are actuarially

equivalent to at least 60 percent of the full actuarial value of the benefits provided under the plan. An actuarial value of 60 percent corresponds to a bronze tier plan under the ACA.

The 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.

The 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.

Preventing surprise bills for emergency medical services and other items and services

This bill requires defined network plans, such as health maintenance organizations, and certain preferred provider plans and self-insured governmental plans that cover benefits or services provided in either an emergency department of a hospital or an independent freestanding emergency department to cover emergency medical services without requiring a prior authorization determination and without regard to whether the health care provider providing the emergency medical services is a participating provider or facility. If the emergency medical services for which coverage is required are provided by a nonparticipating provider, the plan must 1) not impose a prior authorization requirement or other limitation that is more restrictive than if the service was provided by a participating provider; 2) not impose cost sharing on an enrollee that is greater than the cost sharing required if the service was provided by a participating provider; 3) calculate the cost-sharing amount to be equal to the recognized amount specified under federal law; 4) provide, within 30 days of the provider's or facility's bill, an initial payment or denial notice to the provider or facility and then pay a total amount to the provider or facility that is equal to the amount by which an out-of-network rate exceeds the amount it received in cost sharing from the enrollee; and 5) count any

cost-sharing payment made by the enrollee for the emergency medical services toward any in-network deductible or out-of-pocket maximum as if the cost-sharing payment was made for services provided by a participating provider or facility.

For coverage of an item or service that is provided by a nonparticipating provider in a participating facility, a plan must 1) not impose a cost-sharing requirement for the item or service that is greater than the cost-sharing requirement that would have been imposed if the item or service was provided by a participating provider; 2) calculate the cost-sharing amount to be equal to the recognized amount specified under federal law; 3) provide, within 30 days of the provider's bill, an initial payment or denial notice to the provider and then pay a total amount to the provider that is equal to the amount by which the out-of-network rate exceeds the amount it received in cost sharing from the enrollee; and 4) count any cost-sharing payment made by the enrollee for the items or services toward any in-network deductible or out-of-pocket maximum as if the cost-sharing payment was made for items or services provided by a participating provider. A nonparticipating provider providing an item or service in a participating facility may not bill or hold liable an enrollee for more than the cost-sharing amount unless the provider provides notice and obtains consent as described in the bill. However, if the nonparticipating provider is providing an ancillary item or service that is specified in the bill, and the commissioner of insurance has not specifically allowed providers to bill or hold an enrollee liable for that item or service by rule, the nonparticipating provider providing the ancillary item or service in a participating facility may not bill or hold liable an enrollee for more than the cost-sharing amount.

Under the bill, a provider or facility that is entitled to a payment for an emergency medical service or other item or service may initiate open negotiations with the defined network plan, preferred provider plan, or self-insured governmental health plan to determine the amount of payment. If the open negotiation period terminates without determination of the payment amount, the provider, facility, or plan may initiate the independent dispute resolution process as specified by the commissioner of insurance. If an enrollee of a plan is a continuing care patient, as defined in the bill, and is obtaining services from a participating provider or facility, and the contract is terminated because of a change in the terms of the participation of the provider or facility in the plan or the contract is terminated, resulting in a loss of benefits under the plan, the plan must notify the enrollee of the enrollee's right to elect to continue transitional care, provide the enrollee an opportunity to notify the plan of the need for transitional care, and allow the enrollee to continue to have the benefits provided under the plan under the same terms and conditions as would have applied without the termination until either 90 days after the termination notice date or the date on which the enrollee is no longer a continuing care patient, whichever is earlier.

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

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

SECTION 1. 609.04 of the statutes is created to read:

609.04 Preventing surprise medical bills; emergency medical services. (1) DEFINITIONS. In this section:

(a) "Emergency medical condition" means all of the following:

1. A medical condition, including a mental health condition or substance use disorder condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy.

b. Serious impairment of bodily function.

c. Serious dysfunction of any bodily organ or part.

2. With respect to a pregnant woman who is having contractions, a medical condition for which there is inadequate time to safely transfer the pregnant woman to another hospital before delivery or for which the transfer may pose a threat to the health or safety of the pregnant woman or the unborn child.

(b) "Emergency medical services," with respect to an emergency medical condition, has the meaning given for "emergency services" in 42 USC 300gg-111 (a) (3) (C).

(c) "Independent freestanding emergency department" has the meaning given in 42 USC 300gg-111 (a) (3) (D).

(d) "Out-of-network rate" has the meaning given by the commissioner by rule or, in the absence of such rule, the meaning given in 42 USC 300gg-111 (a) (3) (K).

(e) "Preferred provider plan," notwithstanding s. 609.01 (4), includes only any preferred provider plan, as defined in s. 609.01 (4), that has a network of participating providers and imposes on enrollees different requirements for using providers that are not participating providers.

(f) "Recognized amount" has the meaning given by the commissioner by rule or, in the absence of such rule, the meaning given in 42 USC 300gg-111 (a) (3) (H).

(g) "Self-insured governmental plan" means a self-insured health plan of the state or a county, city, village, town, or school district that has a network of participating providers and imposes on enrollees in the self-insured health plan different requirements for using providers that are not participating providers.

(h) "Terminated" means the expiration or nonrenewal of a contract. "Terminated" does not include a termination of a contract for failure to meet applicable quality standards or for fraud.

(2) EMERGENCY MEDICAL SERVICES. A defined network plan, preferred provider plan, or self-insured governmental plan that covers any benefits or services provided in an emergency department of a hospital or emergency medical services provided in an independent freestanding emergency department shall cover emergency medical services in accordance with all of the following:

(a) The plan may not require a prior authorization determination.

(b) The plan may not deny coverage on the basis of whether or not the health care provider providing the services is a participating provider or participating facility.

(c) If the emergency medical services are provided to an enrollee by a provider or in a facility that is not a participating provider or participating facility, the plan complies with all of the following:

1. The emergency medical services are covered without imposing on an enrollee a requirement for prior authorization or any coverage limitation that is more restrictive than requirements or limitations that apply to emergency medical services provided by participating providers or in participating facilities.

2. Any cost-sharing requirement imposed on an enrollee for the emergency medical services is no greater than the requirements that would apply if the emergency medical services were provided by a participating provider or in a participating facility.

3. Any cost-sharing amount imposed on an enrollee for the emergency medical services is calculated as if the total amount that would have been charged for the emergency medical services if provided by a participating provider or in a participating facility is equal to the recognized amount for such services, plan or coverage, and year.

4. The plan does all of the following:

a. No later than 30 days after the participating provider or participating facility transmits to the plan the bill for emergency medical services, sends to the provider or facility an initial payment or a notice of denial of payment.

b. Pays to the participating provider or participating facility a total amount that, incorporating any initial payment under subd. 4. a., is equal to the amount by which the out-of-network rate exceeds the cost-sharing amount.

5. The plan counts any cost-sharing payment made by the enrollee for the emergency medical services toward any in-network deductible or out-of-pocket maximum applied by the plan in the same manner as if the cost-sharing payment was made for emergency medical services provided by a participating provider or in a participating facility.

(3) NONPARTICIPATING PROVIDER IN PARTICIPATING FACILITY. For items or services other than emergency medical services that are provided to an enrollee of a defined network plan, preferred provider plan, or self-insured governmental plan by a provider who is not a participating provider but who is providing services at a participating facility, the plan shall provide coverage for the item or service in accordance with all of the following:

(a) The plan may not impose on an enrollee a cost-sharing requirement for the item or service that is greater than the cost-sharing requirement that would have been imposed if the item or service was provided by a participating provider.

(b) Any cost-sharing amount imposed on an enrollee for the item or service is calculated as if the total amount that would have been charged for the item or service if provided by a participating provider is equal to the recognized amount for such item or service, plan or coverage, and year.

(c) No later than 30 days after the provider transmits the bill for services, the plan shall send to the provider an initial payment or a notice of denial of payment.

(d) The plan shall make a total payment directly to the provider who provided the item or service to the enrollee that, added to any initial payment described under par. (c), is equal to the amount by which the out-of-network rate for the item or service exceeds the cost-sharing amount.

(e) The plan counts any cost-sharing payment made by the enrollee for the item or service toward any in-network deductible or out-of-pocket maximum applied by the plan in the same manner as if the cost-sharing payment was made for the item or service when provided by a participating provider.

(4) CHARGING FOR SERVICES BY NONPARTICIPATING PROVIDER; NOTICE AND CONSENT. (a) Except as provided in par. (c), a provider of an item or service who is entitled to payment under sub. (3) may not bill or hold liable an enrollee for any amount for the item or service that is more than the cost-sharing amount calculated under sub. (3) (b) for the item or service unless the nonparticipating provider provides notice and obtains consent in accordance with all of the following:

1. The notice states that the provider is not a participating provider in the enrollee's defined network plan, preferred provider plan, or self-insured governmental plan.

2. The notice provides a good faith estimate of the amount that the nonparticipating provider may charge the enrollee for the item or service involved, including notification that the estimate does not constitute a contract with respect to the charges estimated for the item or service.

3. The notice includes a list of the participating providers at the participating

facility who would be able to provide the item or service and notification that the enrollee may be referred to one of those participating providers.

4. The notice includes information about whether or not prior authorization or other care management limitations may be required before receiving an item or service at the participating facility.

5. The notice clearly states that consent is optional and that the patient may elect to seek care from an in-network provider.

6. The notice is worded in plain language.

7. The notice is available in languages other than English. The commissioner shall identify languages for which the notice should be available.

8. The enrollee provides consent to the nonparticipating provider to be treated by the nonparticipating provider, and the consent acknowledges that the enrollee has been informed that the charge paid by the enrollee may not meet a limitation that the enrollee's defined network plan, preferred provider plan, or self-insured governmental plan places on cost sharing, such as an in-network deductible.

9. A signed copy of the consent described under subd. 8. is provided to the enrollee.

(b) To be considered adequate, the notice and consent under par. (a) shall meet one of the following requirements, as applicable:

1. If the enrollee makes an appointment for the item or service at least 72 hours before the day on which the item or service is to be provided, any notice under par. (a) shall be provided to the enrollee at least 72 hours before the day of the appointment at which the item or service is to be provided.

2. If the enrollee makes an appointment for the item or service less than 72 hours before the day on which the item or service is to be provided, any notice under par. (a) shall be provided to the enrollee on the day that the appointment is made.

(c) A provider of an item or service who is entitled to payment under sub. (3) may not bill or hold liable an enrollee for any amount for an ancillary item or service that is more than the cost-sharing amount calculated under sub. (3) (b) for the item or service, whether or not provided by a physician or non-physician practitioner, unless the commissioner specifies by rule that the provider may bill or hold the enrollee liable for the ancillary item or service, if the item or service is any of the following:

1. Related to an emergency medical service.

2. Anesthesiology.

3. Pathology.

4. Radiology.

5. Neonatology.

6. An item or service provided by an assistant surgeon, hospitalist, or intensivist.

7. A diagnostic service, including a radiology or laboratory service.

8. An item or service provided by a specialty practitioner that the commissioner specifies by rule.

9. An item or service provided by a nonparticipating provider when there is no participating provider who can furnish the item or service at the participating facility.

(d) Any notice and consent provided under par. (a) may not extend to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is provided.

(e) Any consent provided under par. (a) shall be retained by the provider for no less than 7 years.

(5) NOTICE BY PROVIDER OR FACILITY. Beginning no later than January 1, 2026, a health care provider or health care facility shall make available, including posting on a website, to enrollees in defined network plans, preferred provider plans, and self-insured governmental plans notice of the requirements on a provider or facility under sub. (4), of any other applicable state law requirements on the provider or facility with respect to charging an enrollee for an item or service if the provider or facility does not have a contractual relationship with the plan, and of information on contacting appropriate state or federal agencies in the event the enrollee believes the provider or facility violates any of the requirements under this section or other applicable law.

(6) NEGOTIATION; DISPUTE RESOLUTION. A provider or facility that is entitled to receive an initial payment or notice of denial under sub. (2) (c) 4. a. or (3) (c) may initiate, within 30 days of receiving the initial payment or notice of denial, open negotiations with the defined network plan, preferred provider plan, or self-insured governmental plan to determine a payment amount for an emergency medical service or other item or service for a period that terminates 30 days after initiating open negotiations. If the open negotiation period under this subsection terminates without determination of a payment amount, the provider, facility, defined network

plan, preferred provider plan, or self-insured governmental plan may initiate, within the 4 days beginning on the day after the open negotiation period ends, the independent dispute resolution process as specified by the commissioner. If the independent dispute resolution decision-maker determines the payment amount, the party to the independent dispute resolution process whose amount was not selected shall pay the fees for the independent dispute resolution. If the parties to the independent dispute resolution reach a settlement on the payment amount, the parties to the independent dispute resolution shall equally divide the payment for the fees for the independent dispute resolution.

(7) CONTINUITY OF CARE. (a) In this subsection:

1. "Continuing care patient" means an individual who is any of the following:

a. Undergoing a course of treatment for a serious and complex condition from a provider or facility.

b. Undergoing a course of institutional or inpatient care from a provider or facility.

c. Scheduled to undergo nonelective surgery, including receipt of postoperative care, from a provider or facility.

d. Pregnant and undergoing a course of treatment for the pregnancy from a provider or facility.

e. Terminally ill and receiving treatment for the illness from a provider or facility.

2. "Serious and complex condition" means any of the following:

a. In the case of an acute illness, a condition that is serious enough to require

specialized medical treatment to avoid the reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period.

(b) If an enrollee is a continuing care patient and is obtaining items or services from a participating provider or participating facility and the contract between the defined network plan, preferred provider plan, or self-insured governmental plan and the provider or facility is terminated because of a change in the terms of the participation of the provider or facility in the plan or the contract between the defined network plan, preferred provider plan, or self-insured governmental plan and the provider or facility is terminated, resulting in a loss of benefits provided under the plan, the plan shall do all of the following:

1. Notify each enrollee of the termination of the contract or benefits and of the right for the enrollee to elect to continue transitional care from the participating provider or participating facility under this subsection.

2. Provide the enrollee an opportunity to notify the plan of the need for transitional care.

3. Allow the enrollee to elect to continue to have the benefits provided under the plan under the same terms and conditions as would have applied to the item or service if the termination had not occurred for the course of treatment related to the enrollee's status as a continuing care patient beginning on the date on which the notice under subd. 1. is provided and ending 90 days after the date on which the

notice under subd. 1. is provided or the date on which the enrollee is no longer a continuing care patient, whichever is earlier.

(c) The provisions of s. 609.24 apply to a continuing care patient to the extent that s. 609.24 does not conflict with this subsection so as to limit the enrollee's rights under this subsection.

(8) RULE MAKING. The commissioner may promulgate any rules necessary to implement this section, including specifying the independent dispute resolution process under sub. (6). The commissioner may promulgate rules to modify the list of those items and services for which a provider may not bill or hold liable an enrollee under sub. (4) (c). In promulgating rules under this subsection, the commissioner may consider any rules promulgated by the federal department of health and human services pursuant to the federal No Surprises Act, 42 USC 300gg-111, et seq.

SECTION 2. 609.24 (5) of the statutes is created to read:

609.24 **(5)** DURATION OF BENEFITS. If an enrollee is a continuing care patient, as defined in s. 609.04 (7) (a), and if any of the situations described under s. 609.04 (7) (b) (intro.) applies, all of the following apply to the enrollee's defined network plan:

(a) Subsection (1) (c) shall apply to any of the participating providers providing the enrollee's course of treatment under s. 609.04 (7), including the enrollee's primary care physician.

(b) Subsection (1) (c) shall apply to lengthen the period in which benefits are

provided under s. 609.04 (7) (b) 3. but may not be applied to shorten the period in which benefits are provided under s. 609.04 (7) (b) 3.

(c) Subsection (1) (d) may not be applied in a manner that limits the enrollee's rights under s. 609.04 (7) (b) 3.

(d) No plan may contract or arrange with a participating provider to provide notice of the termination of the participating provider's participation, pursuant to sub. (4).

SECTION 3. 609.712 of the statutes is created to read:

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

SECTION 4. 609.74 of the statutes is created to read:

609.74 Coverage of infertility services. Defined network plans and preferred provider plans are subject to s. 632.895 (15m).

SECTION 5. 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 6. 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 7. 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 8. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. Except as provided in ~~s.~~ ss. 632.728 and 632.729, 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 ss. 632.365, 632.728, and 632.729, 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 9. 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 10. 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) "Cost sharing" includes deductibles, coinsurance, copayments, or similar charges.

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

(c) "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 the sexual orientation, the gender identity, or any preexisting condition of any individual or employee who will be covered by the plan. 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 that is no shorter than 30 days, during which every individual health benefit plan shall 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 an otherwise 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) STATEWIDE RISK POOL. An insurer offering a health benefit plan may not segregate enrollees into risk pools other than a single statewide risk pool for the individual market and a single statewide risk pool for the small employer market or a single statewide risk pool that combines the individual and small employer markets.

(6) 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.

(7) COST SHARING MAXIMUM. A health benefit plan offered on the individual or small employer market may not require an enrollee under the plan to pay more in cost sharing than the maximum amount calculated under 42 USC 18022 (c), including the annual indexing of the limits.

(8) MEDICAL LOSS RATIO. (a) In this subsection, "medical loss ratio" means

the proportion, expressed as a percentage, of premium revenues spent by a health benefit plan on clinical services and quality improvement.

(b) A health benefit plan on the individual or small employer market shall have a medical loss ratio of at least 80 percent.

(c) A group health benefit plan other than one described under par. (b) shall have a medical loss ratio of at least 85 percent.

(9) ACTUARIAL VALUES OF PLAN TIERS. Any health benefit plan offered on the individual or small employer market shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to at least 60 percent of the full actuarial value of the benefits provided under the plan.

SECTION 11. 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 12. 632.746 (1) (b) of the statutes is repealed.

SECTION 13. 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 14. 632.746 (2) (c), (d) and (e) of the statutes are repealed.

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

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

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

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

SECTION 19. 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 20. 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~~ an otherwise similarly situated individual enrolled under the plan.

SECTION 21. 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~~ limited duration plan 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~~.

****NOTE: This is reconciled s. 632.76 (2) (ac) 2. This SECTION has been affected by drafts with the following LRB numbers: -0814/P2 and -1659/P3.

SECTION 22. 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 23. 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 24. 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 onetime 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 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, except any disability insurance policy that is described in s. 632.745 (11) (b) 1. to 12., 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 specified under par. (b), 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 more than one well-woman visit described under par. (b) 47. is necessary to provide all necessary preventive services as determined by a qualified health care provider and in accordance with applicable recommendations for preventive services, the disability insurance policy or self-insured health plan may not apply a deductible to or impose a copayment or coinsurance on any such well-woman visit.

SECTION 25. 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 26. 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 27. 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 28. 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 29. 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 30. 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 31. 632.895 (15m) of the statutes is created to read:

632.895 **(15m)** COVERAGE OF INFERTILITY SERVICES. (a) In this subsection:

1. "Diagnosis of and treatment for infertility" means any recommended procedure or medication to treat infertility at the direction of a physician that is consistent with established, published, or approved medical practices or professional guidelines from the American College of Obstetricians and Gynecologists, or its successor organization, or the American Society for Reproductive Medicine, or its successor organization.

2. "Infertility" means a disease, condition, or status characterized by any of the following:

a. The failure to establish a pregnancy or carry a pregnancy to a live birth after regular, unprotected sexual intercourse for, if the woman is under the age of 35, no longer than 12 months or, if the woman is 35 years of age or older, no longer than 6 months, including any time during those 12 months or 6 months that the woman has a pregnancy that results in a miscarriage.

b. An individual's inability to reproduce either as a single individual or with a partner without medical intervention.

c. A physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

3. "Self-insured health plan" means a self-insured health plan of the state or a county, city, village, town, or school district.

4. "Standard fertility preservation service" means a procedure that is consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization, for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

(b) Subject to pars. (c) to (e), every disability insurance policy and self-insured health plan that provides coverage for medical or hospital expenses shall cover diagnosis of and treatment for infertility and standard fertility preservation services. Coverage required under this paragraph includes at least 4 completed oocyte retrievals with unlimited embryo transfers, in accordance with the

guidelines of the American Society for Reproductive Medicine, or its successor organization, and single embryo transfer when recommended and medically appropriate.

(c) 1. A disability insurance policy or self-insured health plan may not do any of the following:

a. Impose any exclusion, limitation, or other restriction on coverage required under par. (b) based on a covered individual's participation in fertility services provided by or to a 3rd party.

b. Impose any exclusion, limitation, or other restriction on coverage of medications that are required to be covered under par. (b) that are different from those imposed on any other prescription medications covered under the policy or plan.

c. Impose any exclusion, limitation, cost-sharing requirement, benefit maximum, waiting period, or other restriction on coverage that is required under par. (b) of diagnosis of and treatment for infertility and standard fertility preservation services that is different from an exclusion, limitation, cost-sharing requirement, benefit maximum, waiting period, or other restriction imposed on benefits for services that are covered by the policy or plan and that are not related to infertility.

2. A disability insurance policy or self-insured health plan shall provide coverage required under par. (b) to any covered individual under the policy or plan, including any covered spouse or nonspouse dependent, to the same extent as other pregnancy-related benefits covered under the policy or plan.

(d) The commissioner, after consulting with the department of health services on appropriate treatment for infertility, shall promulgate any rules necessary to implement this subsection. Before the promulgation of rules, disability insurance policies and self-insured health plans are considered to comply with the coverage requirements of par. (b) if the coverage conforms to the standards of the American Society for Reproductive Medicine.

(e) This subsection does not apply to a disability insurance policy that is described under s. 632.745 (11) (b) 1. to 12.

SECTION 32. 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 33. 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 34. 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 35. 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.

SECTION 9323. Initial applicability; Insurance.

(1) COVERAGE OF INFERTILITY SERVICES.

(a) For policies and plans containing provisions inconsistent with these sections, the treatment of ss. 609.74 and 632.895 (15m) 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 pars. (b) and (c).

(b) For policies and plans that have a term greater than one year and contain provisions inconsistent with these sections, the treatment of ss. 609.74 and 632.895 (15m) first applies to policy or plan years beginning on January 1 of the year following the year in which the policy or plan is extended, modified, or renewed, whichever is later.

(c) For policies and plans that are affected by a collective bargaining agreement containing provisions inconsistent with these sections, the treatment of ss. 609.74 and 632.895 (15m) 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.

(2) 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. 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. and 2., 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. 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. and 2., 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.

SECTION 9423. Effective dates; Insurance.

(1) COVERAGE OF INFERTILITY SERVICES. The treatment of ss. 609.74 and 632.895 (15m) and SECTION 9323 (1) of this act take effect on the first day of the 4th month beginning after publication.

(2) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES. The treatment of ss. 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. and 2., 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 (2) of this act take effect on the first day of the 4th month beginning after publication.

(END)