



Review of 2009 Act 28

REQUIRE DHS TO SUBMIT PLAN TO IMPLEMENT UNSPECIFIED MA EFFICIENCIES AND REDUCTIONS

Require DHS to submit to the Joint Committee on Finance, by August 1, 2009, its plan to administer the MA and SeniorCare programs within the funding appropriated for those programs during the 2009-11 biennium. Further, require DHS to include in its plan a description of the manner in which efficiencies and reductions shall be realized, including an estimate of the state and federal cost savings, by state fiscal year, which would result from each component of the plan and from the plan as a whole. Provide that if the Committee does not schedule a meeting and approve an alternative plan by September 1, 2009, the original plan submitted by DHS shall be deemed approved.

COVERAGE OF PODIATRY SERVICES FOR BADGERCARE PLUS CHILDLess ADULTS

Currently, individuals who participate in the childless adults project are covered under the BadgerCare Plus Core plan, which provides coverage for a more limited set of services than are provided to most BadgerCare Plus enrollees under the standard plan and benchmark plan. Podiatry services are currently covered under the standard plan and the benchmark plan, but not under the BadgerCare Plus Core plan. The law under Act 28 will now require DHS to cover services provided by podiatrists, within the scope of a podiatrist's professional license, to individuals who are eligible for the childless adults demonstration project if the services are covered when provided by a physician to these individuals

CREATE NEW ELIGIBILITY CATEGORY FOR COVERAGE UNDER THE BADGERCARE PLUS BENCHMARK PLAN

BadgerCare Plus provides health care coverage to its members under two different plans: (a) the standard plan, which provides essentially the same level of coverage as the state's previous medical assistance program; and (b) the benchmark plan, which provides more limited benefits and includes higher cost-sharing features. Under current law, children under age 19, parents and caretaker relatives of children, and pregnant women, among others, are eligible for health care coverage under BadgerCare Plus if they satisfy non-financial and financial eligibility factors. With respect to the latter, adults, with the exception of pregnant women for whom a higher threshold applies, are eligible for BadgerCare Plus only if their family income does not exceed 200% of the federal poverty level (FPL). Children are eligible for BadgerCare Plus regardless of their family income, but children in families with income greater than 300% of the FPL are eligible only for the benchmark plan, and only if they pay the full per member per month cost of coverage.

Under Act 28, the new law will provide that an individual is eligible to purchase coverage under the BadgerCare Plus benchmark plan for himself or herself and for his or her spouse and dependent children, at the full per member per month cost of coverage, if all of the following apply: (a) the individual lost his or her employer-sponsored health care coverage as a result of his or her employer's or former employer's bankruptcy; (b) after losing his or her employer-sponsored health care coverage, the individual received health care coverage through a voluntary employment benefit association that was established before August 2006; (c) the individual is not otherwise eligible for coverage under BadgerCare Plus; and (d) the individual is under 65 years of age.

INSURANCE PAYMENT INTERCEPT AND INSURANCE AGENT APPOINTMENT FEES

Act 28 **does not** include any provision that would establish an insurance payment intercept program.

AGENT APPOINTMENT FEES

This section increases the fees paid by insurers for the appointment and renewal of licensed insurance intermediaries to a minimum of \$16 for residents and \$50 for non-residents, but allows the Commissioner to set the fees higher by rule. The statutory language is as follows:

SECTION 3135. 601.31 (1) (n) of the statutes is amended to read:

601.31 (1) (n) For listing appointing, or renewing a listing an appointment of, an agent under s. 628.11, ~~a fee to be set by the commissioner by rule but not to exceed \$8~~ \$16 annually for resident agents or ~~\$24~~ \$50 annually for nonresident agents, unless the commissioner sets a higher fee by rule, to be paid at times and under procedures set by the commissioner.

UNIFORM APPLICATION OF INDIVIDUAL HEALTH INSURANCE POLICIES

The section requires the use of a uniform application by insurers for individual health insurance policies. It requires the OCI to prescribe uniform questions and the format for the application, which may not exceed 10 pages in length. The statutory language is as follows:

SECTION 3136. 601.41 (10) of the statutes is created to read:

601.41 (10) UNIFORM APPLICATION FOR INDIVIDUAL HEALTH INSURANCE POLICIES.

- (a) The commissioner shall by rule prescribe uniform questions and the format for applications, which may not exceed 10 pages in length, for individual major medical health insurance policies.
- (b) After the effective date of the rules promulgated under par. (a), an insurer may use only the prescribed questions and format for individual major medical health insurance policy applications. The commissioner shall publish a notice in the Wisconsin Administrative Register that states the effective date of the rules promulgated under par. (a).
- (c) For purposes of this subsection, an individual major medical health insurance policy includes health coverage provided on an individual basis through an association.

SHORT TERM MAJOR MEDICAL POLICIES

This section restricts the use of short term major medical policies, but also excludes these policies from the expansion of IER for coverage denial determinations and the restrictions on pre-existing conditions limitations. The statutory language is as follows:

SECTION 3173d. 632.7495 (4) of the statutes is renumbered 632.7495 (4) (intro.) and amended to read:

632.7495 (4) (intro.) ~~Notwithstanding~~ Except as the commissioner may provide by rule under sub. (5) and notwithstanding subs. (1) and (2) and s. 631.36 (4), an insurer is not required to renew individual health benefit plan coverage that complies with all of the following: (a) The coverage is marketed and designed to provide short-term coverage as a bridge between coverages.

SECTION 3173f. 632.7495 (4) (b) of the statutes is created to read:

632.7495 (4) (b) The coverage has a term of not more than 12 months.

SECTION 3173h. 632.7495 (4) (c) of the statutes is created to read:

632.7495 (4) (c) The coverage term aggregated with all consecutive periods of the insurer's coverage of the insured by individual health benefit plan coverage not required to be renewed under this subsection does not exceed 18 months. For purposes of this paragraph, coverage periods are consecutive if there are no more than 63 days between the coverage periods.

SECTION 3173j. 632.7495 (4) (d) of the statutes is created to read:

632.7495 (4) (d) Rules promulgated by the commissioner under sub. (5).

SECTION 3173m. 632.7495 (5) of the statutes is created to read:

632.7495 (5) The commissioner shall promulgate rules governing disclosures related to, and may promulgate rules setting standards for, the sale of individual health benefit plans that an insurer is not required to renew under sub. (4).

MODIFICATIONS AT RENEWAL

This section requires an insurer to allow an insured at the time of renewal to modify their plan, and to elect any other plan the insurer offers without being subject to additional underwriting or pre-existing conditions so long as the modification does not increase benefits or the new plan is comparable to the existing plan. The statutory language is as follows:

SECTION 3174. 632.7497 of the statutes is created to read:

632.7497 Modifications at renewal.

(1) In this section, "individual major medical or comprehensive health benefit plan" includes coverage under a group policy that is underwritten on an individual basis and issued to individuals or families.

(2) An insurer that issues an individual major medical or comprehensive health benefit plan shall, at the time of a coverage renewal, at the request of an insured, permit the insured to do either of the following:

(a) Change his or her coverage to any of the following:

1. A different but comparable individual major medical or comprehensive health benefit plan currently offered by the insurer.
2. An individual major medical or comprehensive health benefit plan currently offered by the insurer with more limited benefits.
3. An individual major medical or comprehensive health benefit plan currently offered by the insurer with higher deductibles.

(b) Modify his or her existing coverage by electing an optional higher deductible, if any, under the individual major medical or comprehensive health benefit plan.

(3) (a) The insurer may not impose any new preexisting condition exclusion under the new or modified coverage under sub. (2) that did not apply to the insured's original coverage and shall allow the insured credit under the new or modified coverage for the period of original coverage. (b) For the new or modified coverage, the insurer may not rate for health status other than on the insured's health status at the time the insured applied for the original coverage and as the insured disclosed on the original application.

(4) (a) Annually, the insurer shall mail to each insured under an individual major medical or comprehensive health benefit plan issued by the insurer, a notice that includes all of the following information:

1. That the insured has the right to elect alternative coverage as described in sub. (2).
2. A description of the alternatives available to the insured.
3. The procedure for making the election. (b) The insurer shall mail the notice under par. (a) not more than 3 months nor less than 60 days before the renewal date of the insured's plan.

(5) (a) Nothing in this section requires an insurer to issue alternative coverage under sub. (2) if the insured's coverage may be nonrenewed or discontinued under s.632.7495 (2), (3) (b), or (4). (b) Notwithstanding s. 600.01 (1) (b) 3. and 4., this section applies to a group health benefit plan described in s. 600.01 (1) (b) 3. or 4. if that group health benefit plan is an individual major medical or comprehensive health benefit plan as defined in sub. (1).

PRE-EXISTING CONDITIONS LIMITATIONS

The section restricts the use of pre-existing conditions limitations by prohibiting an insurer from reducing or denying coverage for any claim commencing after 12 months from the date of issue on the ground that the disease or physical condition existed prior to the effective date. In addition, it prohibits an individual health insurance policy from defining a preexisting condition more restrictively than a condition for which medical advice, diagnosis, care or treatment was recommended or received within 12 months before the effective date of coverage. The statutory language is as follows:

SECTION 3176. 632.76 (2) (ac) of the statutes is created to read:

632.76 (2) (ac)

1. Notwithstanding par. (a), no claim or loss incurred or disability commencing after 12 months from the date of issue of 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 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, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within 12 months before the effective date of coverage.
3. Except as the commissioner provides by rule under s. 632.7495 (5), all of the following apply to an individual disability insurance policy that is a short-term policy subject to s. 632.7495 (4) and (5):
 - a. The policy may not define a preexisting condition more restrictively than 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 before the effective date of coverage.
 - b. The policy shall reduce the length of time during which a preexisting condition exclusion may be imposed by the aggregate of the insured's consecutive periods of coverage under the insurer's individual disability insurance policies that are short-term policies subject to s. 632.7495 (4) and (5). For purposes of this subd. 3. b., coverage periods are consecutive if there are no more than 63 days between the coverage periods.

INDEPENDENT REVIEW OF COVERAGE DENIAL DETERMINATIONS AND RESCISSIONS -- INSURER LIABILITY

Modify current IER law relating to the types of adverse decisions that are eligible for a review under a group or individual health benefit plan's independent review procedure to include: (a) the rescission of a policy or certificate; and (b) a coverage denial determination based on a preexisting condition exclusion. A rescission may occur if an insurer determines that a policyholder failed to disclose material information at the time the policyholder applied for coverage under the policy. The decision of the independent review organization, with respect to the two new types of reviewable actions, would not be binding on the insured. It would also allow for the insured to commence a civil proceeding relating to a coverage denial determination. It also removes the \$25 fee the insured was required to pay in order to proceed with an IER. In addition, insurers will be required to report the number policies that were cancelled or rescinded. The statutory language is as follows:

SECTION 3137. 601.428 of the statutes is created to read:

601.428 Cancellation and rescission reports. Beginning in 2009, every insurer that issues individual health insurance policies shall annually report to the commissioner the total number of individual health insurance policies that the insurer issued in the preceding year and the total number of individual health insurance policies with respect to which the insurer initiated or completed a cancellation or rescission in the preceding year.

SECTION 3178. 632.835 (title) of the statutes is amended to read:

632.835 (title) Independent review of ~~adverse and experimental treatment~~ coverage denial determinations.

SECTION 3179. 632.835 (1) (ag) of the statutes is created to read: 632.835 (1) (ag) “Coverage denial determination” means an adverse determination, an experimental treatment determination, a preexisting condition exclusion denial determination, or the rescission of a policy or certificate.

SECTION 3180. 632.835 (1) (cm) of the statutes is created to read:
632.835 (1) (cm) “Preexisting condition exclusion denial determination” means a determination by or on behalf of an insurer that issues a health benefit plan denying or terminating treatment or payment for treatment on the basis of a preexisting condition exclusion, as defined in s. 632.745 (23).

SECTION 3181. 632.835 (2) (a) of the statutes is amended to read:
632.835 (2) (a) Every insurer that issues a health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan, or his or her authorized representative, may request and obtain an independent review of ~~an adverse determination or an experimental treatment~~ a coverage denial determination made with respect to the insured.

SECTION 3182. 632.835 (2) (b) of the statutes is amended to read:
632.835 (2) (b) If ~~an adverse determination or an experimental treatment~~ a coverage denial determination is made, the insurer involved in the determination shall provide notice to the insured of the insured’s right to obtain the independent review required under this section, how to request the review, and the time within which the review must be requested. The notice shall include a current listing of independent review organizations certified under sub. (4). An independent review under this section may be conducted only by an independent review organization certified under sub. (4) and selected by the insured.

SECTION 3183. 632.835 (2) (bg) 3. of the statutes is amended to read:
632.835 (2) (bg) 3. For any ~~adverse determination or experimental treatment~~ coverage denial determination for which an explanation of benefits is not provided to the insured, the insurer provides a notice that the insured may have a right to an independent review after the internal grievance process and that an insured may be entitled to expedited, independent review with respect to an urgent matter. The notice shall also include a reference to the section of the policy or certificate that contains the description of the independent review procedure as required under subd. 1. The notice shall provide a toll-free telephone number and website, if appropriate, where consumers may obtain additional information regarding internal grievance and independent review processes.

SECTION 3184. 632.835 (2) (c) of the statutes is amended to read:
632.835 (2) (c) Except as provided in par. (d), an insured must exhaust the internal grievance procedure under s. 632.83 before the insured may request an independent review under this section. Except as provided in sub. (9) (a), an insured who uses the internal grievance procedure must request an independent review as provided in sub. (3) (a) within 4 months after the insured receives notice of the disposition of his or her grievance under s. 632.83 (3) (d).

SECTION 3185. 632.835 (2) (e) of the statutes is created to read:
632.835 (2) (e) Nothing in this section affects an insured’s right to commence a civil proceeding relating to a coverage denial determination.

SECTION 3186. 632.835 (3) (a) of the statutes is amended to read:
632.835 (3) (a) To request an independent review, an insured or his or her authorized representative shall provide timely written notice of the request for independent review, and of the independent review organization selected, to the insurer that made or on whose behalf was made the ~~adverse or experimental treatment~~ coverage denial determination. The insurer shall immediately notify the commissioner and the independent review organization selected by the insured of the request for independent review. ~~The insured or his or her authorized representative must pay a \$25 fee to the independent review organization. If the insured prevails on the review, in whole or in part, the entire amount paid by the insured or his or her authorized representative shall be refunded by the insurer to the insured or his or her authorized representative.~~ For each independent review in which it is involved, an insurer shall pay a fee to the independent review organization.

SECTION 3187. 632.835 (3) (e) of the statutes is amended to read:
632.835 (3) (e) In addition to the information under pars. (b) and (c), the independent review organization may accept for consideration any typed or printed, verifiable medical or scientific evidence that the independent review organization

determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. The insurer and the insured shall submit to the other party to the independent review any information submitted to the independent review organization under this paragraph and pars. (b) and (c). If, on the basis of any additional information, the insurer reconsiders the insured's grievance and determines that the treatment that was the subject of the grievance should be covered, or that the policy or certificate that was rescinded should be reinstated, the independent review is terminated.

SECTION 3188. 632.835 (3) (f) of the statutes is renumbered 632.835 (3) (f) 1. and amended to read:

632.835 (3) (f) 1. If the independent review is not terminated under par. (e), the independent review organization shall, within 30 business days after the expiration of all time limits that apply in the matter, make a decision on the basis of the documents and information submitted under this subsection. The decision shall be in writing, signed on behalf of the independent review organization and served by personal delivery or by mailing a copy to the insured or his or her authorized representative and to the insurer. Except as provided in subd. 2., a decision of an independent review organization is binding on the insured and the insurer.

SECTION 3189. 632.835 (3) (f) 2. of the statutes is created to read:

632.835 (3) (f) 2. A decision of an independent review organization regarding a preexisting condition exclusion denial determination or a rescission is not binding on the insured.

SECTION 3190. 632.835 (3m) (a) of the statutes is amended to read:

632.835 (3m) (a) A decision of an independent review organization regarding an adverse determination or a preexisting condition exclusion denial determination must be consistent with the terms of the health benefit plan under which the adverse determination or preexisting condition exclusion denial determination was made.

SECTION 3192. 632.835 (7) (b) of the statutes is amended to read:

632.835 (7) (b) A health benefit plan that is the subject of an independent review and the insurer that issued the health benefit plan shall not be liable to any person for damages attributable to the insurer's or plan's actions taken in compliance with any decision regarding an adverse determination or an experimental treatment determination rendered by a certified independent review organization.

SECTION 3193. 632.835 (8) of the statutes is renumbered 632.835 (8) (a) and amended to read:

632.835 (8) (a) Adverse and experimental treatment determinations. The commissioner shall make a determination that at least one independent review organization has been certified under sub. (4) that is able to effectively provide the independent reviews required under this section for adverse determinations and experimental treatment determinations and shall publish a notice in the Wisconsin Administrative Register that states a date that is 2 months after the commissioner makes that determination. The date stated in the notice shall be the date on which the independent review procedure under this section begins operating with respect to adverse determinations and experimental treatment determinations.

SECTION 3194. 632.835 (8) (b) of the statutes is created to read:

632.835 (8) (b) Preexisting condition exclusion denials and rescissions. The commissioner shall make a determination that at least one independent review organization has been certified under sub. (4) that is able to effectively provide the independent reviews required under this section for preexisting condition exclusion denial determinations and rescissions and shall publish a notice in the Wisconsin Administrative Register that states a date that is 2 months after the commissioner makes that determination. The date stated in the notice shall be the date on which the independent review procedure under this section begins operating with respect to preexisting condition exclusion denial determinations and rescissions.

SECTION 3195. 632.835 (9) of the statutes is renumbered 632.835 (9) (a) and amended to read:

632.835 (9) (a) Adverse and experimental treatment determinations. The independent review required under this section with respect to an adverse determination or an experimental treatment determination shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after December 1, 2000. Notwithstanding sub. (2) (c), an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after December 1, 2000, but before June 15, 2002, with respect to an adverse determination or an experimental treatment determination must request an independent review no later than 4 months after June 15, 2002.

SECTION 3196. 632.835 (9) (b) of the statutes is created to read:

632.835 (9) (b) *Preexisting condition exclusion denials and rescissions.* The independent review required under this section with respect to a preexisting condition exclusion denial determination or a rescission shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after the date stated in the notice published in the Wisconsin Administrative Register by the commissioner under sub. (8) (b).

HEALTH INSURANCE COVERAGE -- COVERAGE REQUIREMENT FOR DEPENDENTS

Require all commercial health insurance policies, and all self-insured governmental health plans to offer and provide (if so requested by an insured or an applicant) coverage for an adult child of the insured or applicant, if the child satisfies all of the following criteria:

- a. The child is over 17 but less than 27 years of age;
- b. The child is not married; and
- c. The child is not eligible for coverage under a group health benefit plan that is offered by the child's employer, and for which the child's premium contribution is not greater than the premium amount for his or her coverage as a dependent under this provision.

Additionally, an adult child would be eligible for coverage as a dependent if he or she meets all the following criteria: (a) the child is a full-time student, regardless of age; (b) the child meets the criteria under (b) and (c) of the previous paragraph; (c) the child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis; and (d) the child was under 27 years of age when called to federal active duty.

Determination of Premiums. Require an insurer or self-insured governmental health plan to determine the premium for coverage of a dependent who is over 18 years of age on the same basis as the premium is determined for coverage of a dependent who is 18 years of age or younger. Permit an insurer or self-insured governmental health plan to require that an applicant or insured seeking coverage of a dependent child provide written documentation, initially and annually thereafter, that the dependent child satisfies the criteria for coverage.

Effective Date and Initial Applicability. The new requirements would take effect on the first day of the seventh month beginning after the bill's publication. However, the requirements would first apply to: (a) health policies that are issued or renewed, and governmental or school district self-insured health plans that are established, extended, modified, or renewed, on that date; (b) health policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with these requirements that are issued or renewed on the earlier of the day on which the collective bargaining agreement expires, or the day on which the collective bargaining agreement is extended, modified, or renewed (after the effective date); and (c) governmental or school district self-insured plans covering employees who are affected by a collective bargaining agreement containing provisions that are inconsistent with these requirements that are established, extended, modified, or renewed on the earlier of the day on which the bargaining agreement expires or the day on which the collective bargaining agreement is extended, modified or renewed.

The statutory language is as follows:

SECTION 3197p. 632.885 of the statutes is created to read:

632.885 Coverage of dependents.

(1) DEFINITIONS. In this section:

- (a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).
- (b) "Insured" includes an enrollee.
- (c) "Self-insured health plan" has the meaning given in s. 632.745 (24).

(2) REQUIREMENT TO OFFER DEPENDENT COVERAGE.

(a) Subject to ss. 632.88 and 632.895 (5), every insurer that issues a disability insurance policy, and every self-insured health plan, shall offer and, if so requested by an applicant or an insured, provide coverage for an adult child of the applicant or insured as a dependent of the applicant or insured if the child satisfies all of the following criteria:

1. The child is over 17 but less than 27 years of age.
2. The child is not married.
3. The child is not eligible for coverage under a group health benefit plan, as defined in s. 632.745 (9), that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a dependent under this section.

(b) Notwithstanding par. (a) 1., the coverage requirement under this section applies to an adult child who satisfies all of the following criteria:

1. The child is a full-time student, regardless of age.
2. The child satisfies the criteria under par. (a) 2. and 3.
3. The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.
4. The child was under the age of 27 years when called to federal active duty under subd. 3.

(3) PREMIUM DETERMINATION. An insurer or self-insured health plan shall determine the premium for coverage of a dependent who is over 18 years of age on the same basis as the premium is determined for coverage of a dependent who is 18 years of age or younger.

(4) DOCUMENTATION OF CRITERIA SATISFACTION. An insurer or self-insured health plan may require that an applicant or insured seeking coverage of a dependent child provide written documentation, initially and annually thereafter, that the dependent child satisfies the criteria for coverage under this section.

MINIMUM COVERAGE REQUIREMENTS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

Require health policies to provide coverage for treatment of autism spectrum disorder. These services would be provided to individuals with autism spectrum disorder by qualified providers. Policies would be required to include coverage of: (a) at least \$50,000 for intensive-level services per insured per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of four years; and (b) at least \$25,000 for nonintensive-level services per insured per year. These minimum coverage requirements would be adjusted annually, beginning in 2011, to reflect changes in the consumer price index. Qualified providers include not only psychiatrists, psychologists, social workers, speech-language pathologists, occupational therapists, paraprofessionals working under the supervision of a licensed provider and a professional working under the supervisions of an outpatient mental health clinic. For the purposes of this mandate, "Intensive-level" services means evidence-based therapy. The following is the statutory language:

SECTION 3197w. 632.895 (12m) of the statutes is created to read:

632.895 (12m) TREATMENT FOR AUTISM SPECTRUM DISORDERS.

(a) In this subsection:

1. "Autism spectrum disorder" means any of the following:
 - a. Autism disorder.
 - b. Asperger's syndrome.
 - c. Pervasive developmental disorder not otherwise specified.
2. "Insured" includes an enrollee and a dependent with coverage under the disability insurance policy or self-insured health plan.
3. "Intensive-level services" means evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder.
4. "Nonintensive-level services" means evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.
5. "Physician" has the meaning given in s. 146.34 (1) (g).

(b) Subject to pars. (c) and (d), and except as provided in par. (e), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village, or school district, shall provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by any of the following who are qualified to provide intensive-level services or nonintensive-level services:

1. A psychiatrist, as defined in s. 146.34 (1) (h).
2. A person who practices psychology, as described in s. 455.01 (5).
3. A social worker, as defined in s. 252.15 (1) (er), who is certified or licensed to practice psychotherapy, as defined in s. 457.01 (8m).
4. A paraprofessional working under the supervision of a provider listed under subds. 1. to 3.
5. A professional working under the supervision of an outpatient mental health clinic certified under s. 51.038.
6. A speech-language pathologist, as defined in s.459.20 (4).
7. An occupational therapist, as defined in s. 448.96 (4).

(c) 1. The coverage required under par. (b) shall provide at least \$50,000 for intensive-level services per insured per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years, and at least \$25,000 for nonintensive-level services per insured per year, except that these minimum coverage monetary amounts shall be adjusted annually, beginning in 2011, to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor. The commissioner shall publish the new minimum coverage amounts under this subdivision each year, beginning in 2011, in the Wisconsin Administrative Register. 2. Notwithstanding subd. 1., the minimum coverage monetary amounts or duration required for treatment under subd. 1., need not be met if it is determined by a supervising professional, in consultation with the insured's physician, that less treatment is medically appropriate.

(d) The coverage required under par. (b) may be subject to deductibles, coinsurance, or copayments that generally apply to other conditions covered under the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

(e) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.
2. 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).
3. A long-term care insurance policy. 4. A medicare replacement policy or a medicare supplement policy.

(f) 1. The commissioner shall by rule further define "intensive-level services" and "nonintensive-level services" and define "paraprofessional" for purposes of par. (b) 4. and "qualified" for purposes of providing services under this subsection. The commissioner may promulgate rules governing the interpretation or administration of this subsection. 2. Using the procedure under s. 227.24, the commissioner may promulgate the rules under subd. 1. for the period before the effective date of the permanent rules promulgated under subd. 1., but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subdivision as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subdivision.

HEALTH INSURANCE CLAIM DENIAL - COVERAGE EVEN IF PROVIDED UNDER LIABILITY POLICY

This section would prohibit health care plans to deny coverage on the bases that there may be coverage for the services under a liability insurance policy. The statutory language is as follows:

SECTION 3197. 632.845 of the statutes is created to read:

632.845 Prohibiting refusal to cover services because liability policy may cover.

- (1) In this section, "health care plan" has the meaning given in s. 628.36 (2) (a) 1.
- (2) An insurer that provides coverage under a health care plan may not refuse to cover health care services that are provided to an insured under the plan and for which there is coverage under the plan on the basis that there may be coverage for the services under a liability insurance policy.

MENTAL HEALTH EXPANSION OF PROVIDERS

The types of providers that insurers are required to reimburse for alcoholism and mental health services has been expanded to include social workers and marriage and family counselors. The exact statutory language is as follows:

SECTION 3197r. 632.89 (1) (dm) of the statutes is created to read:

632.89 (1) (dm) “Licensed mental health professional” means a clinical social worker who is licensed under ch. 457, a marriage and family therapist who is licensed under s. 457.10, or a professional counselor who is licensed under s. 457.12.

HEALTH INSURANCE COVERAGE – CONTRACEPTIVE MANDATE

The section requires all insurers to cover contraceptives and services. The statutory language is as follows:

SECTION 3198d. 632.895 (17) of the statutes is created to read:

632.895 (17) CONTRACEPTIVES AND SERVICES.

- (a) In this subsection, “contraceptives” means drugs or devices approved by the federal food and drug administration to prevent pregnancy.
 - (b) Every disability insurance policy, and every self-insured health plan of the state or of a county, city, town, village, or school district, that provides coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices shall provide coverage for all of the following:
 - 1. Contraceptives prescribed by a health care provider, as defined in s. 146.81 (1).
 - 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.
 - (c) Coverage under par. (b) may be subject only to the exclusions, 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.
 - (d) This subsection does not apply to any of the following:
 - 1. A disability insurance policy that covers only certain specified diseases.
 - 2. A disability insurance policy, or a self-insured health plan of the state or a county, city, town, village, or school district, that provides only limited-scope dental or vision benefits.
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). 4. A long-term care insurance policy. 5. A Medicare replacement policy or a Medicare supplement policy.

INITIAL APPLICABILITY

The applicability of these provisions not previously defined are as follows:

SECTION 9326.0Initial applicability; Insurance. (1) AGENT APPOINTMENT FEES. The treatment of section 601.31 (1) (n) of the statutes first applies to fees for appointments and renewals of appointments paid on the effective date of this subsection. (3) MODIFICATIONS AT RENEWAL. The treatment of section 632.7497 of the statutes first applies to individual major medical or comprehensive health benefit plans that are renewed on the effective date of this subsection. (3u) RENEWAL EXCEPTION FOR SHORT-TERM PLANS. The treatment of section 632.7495 (5) of the statutes, the renumbering and amendment of section 632.7495 (4) of the statutes, and the creation of section 632.7495 (4) (b), (c), and (d) of the statutes first apply to individual health benefit plans that are short-term plans and that are issued or renewed on the effective date of this subsection. (4) PREEXISTING CONDITION EXCLUSIONS. The treatment of section 632.76 (2) (ac) and (b) of the statutes first applies to individual disability insurance policies that are issued or renewed on the effective date of this subsection.