State of Wisconsin
2019 - 2020 LEGISLATURE

LRBa0015/1
TJD:cjs

ASSEMBLY AMENDMENT 2,

TO ASSEMBLY BILL 1

January 16, 2019 – Offered by Representative ROHRKASTE.

At the locations indicated, amend the bill as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b)".

(END)