State of Wisconsin
2021 - 2022 LEGISLATURE

LRBb0036/2
TD/JC/SW/EL:all

ASSEMBLY AMENDMENT 2,

TO ASSEMBLY SUBSTITUTE AMENDMENT 2,

TO ASSEMBLY BILL 68

June 29, 2021 – Offered by Representatives SUBECK, ANDERSON, ANDRACA, BALDEH, BILLINGS, BOWEN, BROSTOFF, CABRERA, CONLEY, CONSIDINE, DOYLE, DRAKE, EMERSON, GOYKE, HAYWOOD, HEBL, HESSELBEIN, HINTZ, HONG, MCGUIRE, B. MEYERS, MILROY, MOORE OMOKUNDE, L. MYERS, NEUBAUER, OHNSTAD, ORTIZ-VELEZ, POPE, RIEMER, S. RODRIGUEZ, SHANKLAND, SHELTON, SINICKI, SNODGRASS, SPREITZER, STUBBS, VINING and VRUWINK.

At the locations indicated, amend the substitute amendment as follows:

1. Page 8, line 9: after that line insert:

"**SECTION 9g.** 15.07 (3) (bm) 7. of the statutes is created to read:

15.07 **(3)** (bm) 7. The prescription drug affordability review board shall meet at least 4 times each year.

SECTION 9m. 15.197 (20) of the statutes is created to read:

15.197 **(20)** SPINAL CORD INJURY COUNCIL. (a) There is created in the department of health services a spinal cord injury council that, except as provided in par. (b), consists of the following members appointed by the department for 2–year terms:

1. One member representing the University of Wisconsin School of Medicine and Public Health.

2. One member representing the Medical College of Wisconsin.

3. One member who has a spinal cord injury.

4. One member who is a family member of a person with a spinal cord injury.

5. One member who is a veteran who has a spinal cord injury.

6. One member who is a physician specializing in the treatment of spinal cord injuries.

7. One member who is a researcher in the field of neurosurgery.

8. One member who is a researcher employed by the veterans health administration of the U.S. department of veterans affairs.

(b) If the department of health services is unable to appoint a member specified in par. (a) 1. to 8., the department of health services may appoint a member representing the general public in lieu of the member so specified.".

2. Page 8, line 14: after that line insert:

"**SECTION 10m.** 15.735 of the statutes is created to read:

15.735 Same; attached board. (1) There is created a prescription drug affordability review board attached to the office of the commissioner of insurance under s. 15.03. The board shall consist of the following members:

(a) The commissioner of insurance or his or her designee.

(b) Two members appointed for 4–year terms who represent the pharmaceutical drug industry, including pharmaceutical drug manufacturers and wholesalers. At least one of the members appointed under this paragraph shall be a licensed pharmacist.

(c) Two members appointed for 4–year terms who represent the health insurance industry, including insurers and pharmacy benefit managers.

(d) Two members appointed for 4–year terms who represent the health care industry, including hospitals, physicians, pharmacies, and pharmacists. At least one of the members appointed under this paragraph shall be a licensed practitioner.

(e) Two members appointed for 4–year terms who represent the interests of the public.

(2) A member appointed under sub. (1) may not be an employee of, a board member of, or a consultant to a drug manufacturer or trade association for drug manufacturers.

(3) Any conflict of interest, including any financial or personal association, that has the potential to bias or has the appearance of biasing an individual's decision in matters related to the board or the conduct of the board's activities shall be considered and disclosed when appointing that individual to the board under sub. (1).".

3. Page 36, line 18: after that line insert:

"(a) State operations GPR A 1,723,000 1,052,300".

4. Page 36, line 19: increase the dollar amount for fiscal year 2022–23 by $3,000,000 for the purpose of developing and implementing a state–based health insurance exchange as described in this act.

5. Page 36, line 19: increase the dollar amount for fiscal year 2022–23 by $900,000 for an analysis and actuarial study for the development of a public option health insurance plan.

6. Page 36, line 19: increase the dollar amount for fiscal year 2021–22 by $1,701,000 to provide $500,000 in onetime implementation costs for establishing an office of prescription drug affordability in the office of the commissioner of insurance

and $1,201,000 to authorize 16.0 PR positions within the office of prescription drug affordability, including 5.0 insurance examiners, 4.0 policy initiatives advisors, 2.0 attorneys, 1.0 insurance program manager, 2.0 insurance administrators, and 2.0 operations program associates and increase the dollar amount for fiscal year 2022–23 by $1,533,900 for the purpose of funding these authorized positions.

7. Page 134, line 4: increase the dollar amount for fiscal year 2021–22 by $1,564,300 and increase the dollar amount for fiscal year 2022–23 by $2,044,100 for the purpose of increasing the authorized FTE positions for the department of health services by 23.0 GPR positions, including 17.0 permanent positions and 6.0 4–year project positions, beginning in fiscal year 2021–22, for the bureau of communicable diseases to prevent and respond to future outbreaks of communicable disease.

8. Page 134, line 4: increase the dollar amount for fiscal year 2021–22 by $189,300 and increase the dollar amount for fiscal year 2022–23 by $246,000 for the purpose of increasing the authorized FTE positions for the department of health services by 3.0 GPR positions, beginning in fiscal year 2021–22, to create a field team in the bureau of communicable diseases dedicated to harm reduction.

9. Page 134, line 4: increase the dollar amount for fiscal year 2021–22 by $162,400 and increase the dollar amount for fiscal year 2022–23 by $213,500 for the purpose of increasing the authorized FTE positions for the department of health services by 2.0 GPR positions, beginning in fiscal year 2021–22, to create a data analysis team in the office of health informatics consisting of a senior statistician and a modeler, dedicated to analyzing health metrics and creating predictive models to inform public health responses.

10. Page 134, line 4: increase the dollar amount for fiscal year 2021–22 by $116,600 and increase the dollar amount for fiscal year 2022–23 by $153,100 for the purpose of converting 2.0 FED positions in the department of health services to 2.0 GPR positions, beginning in fiscal year 2021–22, to support 1.0 state trauma coordinator and 1.0 trauma program associate with state funds rather than funds received under the federal hospital preparedness program.

11. Page 134, line 4: increase the dollar amount for fiscal year 2021–22 by $100,000 and increase the dollar amount for fiscal year 2022–23 by $100,000 for the purpose of contracting for the services of one full–time web developer in the division of public health to translate the Internet pages of the department of health services into multiple languages.

12. Page 134, line 4: increase the dollar amount for fiscal year 2021–22 by $66,200 and increase the dollar amount for fiscal year 2022–23 by $88,200 for the purpose of increasing the authorized FTE positions for the department of health services by 1.0 GPR position, beginning in fiscal year 2021–22, to create an interdepartmental team to promote health in all policies.

13. Page 134, line 4: increase the dollar amount for fiscal year 2022–23 by $87,600 for the purpose of increasing the authorized FTE positions for the department of health services by 1.0 GPR position, beginning in fiscal year 2022–23, to oversee a self–reported compliance program for ambulance medical equipment and operational requirements and conduct inspections as necessary.

14. Page 134, line 8: increase the dollar amount for fiscal year 2021–22 by $655,000 and increase the dollar amount for fiscal year 2022–23 by $655,000 for grants to support health information exchange activities.

15. Page 134, line 8: increase the dollar amount for fiscal year 2021–22 by $500,000 and increase the dollar amount for fiscal year 2022–23 by $500,000 for the purpose of awarding a grant in each fiscal year to an entity to connect and convene efforts among state agencies, public and private sector organizations, and community organizations to support a statewide public health strategy to advance Black women's health.

16. Page 135, line 2: after that line insert:

"(cd) Spinal cord injury research GPR S 1,500,000 1,500,000".

17. Page 135, line 6: increase the dollar amount for fiscal year 2021–22 by $5,000,000 and increase the dollar amount for fiscal year 2022–23 by $5,000,000 for the purpose of grants to local public health departments to prevent and control communicable diseases.

18. Page 135, line 7: increase the dollar amount for fiscal year 2021–22 by $125,000 and increase the dollar amount for fiscal year 2022–23 by $125,000 for the purpose of awarding a grant to an organization to train and assist guardians for individuals found to be incompetent under ch. 54.

19. Page 135, line 13: increase the dollar amount for fiscal year 2021–22 by $3,500,000 and increase the dollar amount for fiscal year 2022–23 by $3,500,000 for the purpose of Black women's health grants under s. 250.20 (7) and for infant and maternal mortality grants under s. 250.20 (8).

20. Page 135, line 17: increase the dollar amount for fiscal year 2021–22 by $321,800 and increase the dollar amount for fiscal year 2022–23 by $321,800 for the purpose of increasing funding for the hearing aid assistance program.

21. Page 136, line 9: increase the dollar amount for fiscal year 2021–22 by $961,800 and increase the dollar amount for fiscal year 2022–23 by $1,054,800 for the purpose of increasing the authorized FTE positions for the department of health services by 1.0 GPR position, beginning in fiscal year 2021–22, to resume the Window Plus lead exposure prevention program.

22. Page 136, line 21: increase the dollar amount for fiscal year 2021–22 by $1,000,000 and increase the dollar amount for fiscal year 2022–23 by $1,000,000 for grants for federally qualified health centers.

23. Page 136, line 21: increase the dollar amount for fiscal year 2021–22 by $1,000,000 and increase the dollar amount for fiscal year 2022–23 by $1,000,000 for free and charitable clinic grants.

24. Page 137, line 4: increase the dollar amount for fiscal year 2021–22 by $2,000,000 for the purpose of a public health campaign aimed at preventing initiation of tobacco and vapor product use as provided under s. 255.15 (3) (d).

25. Page 139, line 2: increase the dollar amount for fiscal year 2021–22 by $5,827,600 and increase the dollar amount for fiscal year 2022–23 by $5,827,600 for the purpose of paying anticipated overtime costs at care and treatment residential facilities owned by the department of health services.

26. Page 139, line 2: increase the dollar amount for fiscal year 2021–22 by $3,028,200 and increase the dollar amount for fiscal year 2022–23 by $3,028,200 for the purpose of increasing the authorized FTE positions for the department of health services by 36.5 GPR positions, beginning in fiscal year 2021–22, to staff a 14–bed unit for adult forensic patients in the building at the Mendota Mental Health Institute that houses the Mendota Juvenile Treatment Center.

27. Page 139, line 8: increase the dollar amount for fiscal year 2021–22 by $2,273,800 and increase the dollar amount for fiscal year 2022–23 by $2,273,800 for the purpose of contracting for treatment delivered under an assertive community treatment model for individuals with serious mental illness that are involved in the criminal justice system.

28. Page 139, line 12: increase the dollar amount for fiscal year 2021–22 by $20,000 for the behavioral health bed tracking system grant.

29. Page 139, line 22: increase the dollar amount for fiscal year 2021–22 by $3,351,800 and increase the dollar amount for fiscal year 2022–23 by $3,351,800 for the purpose of paying anticipated overtime costs at care and treatment residential facilities owned by the department of health services.

30. Page 140, line 19: decrease the dollar amount for fiscal year 2021–22 by $849,788,000 and decrease the dollar amount for fiscal year 2022–23 by $841,925,400 as a result of the expansion of eligibility for the Medical Assistance program.

31. Page 140, line 19: decrease the dollar amount for fiscal year 2021–22 by $1,390,700 and decrease the dollar amount for fiscal year 2022–23 by $2,026,500 for the purpose of decreasing the nursing home reimbursement.

32. Page 140, line 19: decrease the dollar amount for fiscal year 2021–22 by $5,000,000 and decrease the dollar amount for fiscal year 2022–23 by $5,000,000 for the purpose of decreasing direct care workforce funding.

33. Page 140, line 19: decrease the dollar amount for fiscal year 2021–22 by $2,844,100 and decrease the dollar amount for fiscal year 2022–23 by $5,000,000 for the purpose of decreasing personal care reimbursement.

34. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $1,145,100 and increase the dollar amount for fiscal year 2022–23 by $2,290,200 to increase Medical Assistance reimbursement rates for emergency physician services.

35. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $1,293,300 and increase the dollar amount for fiscal year 2022–23 by $2,586,700 for the purpose of providing an additional increase to the Medical Assistance reimbursement rates for medication–assisted treatment services.

36. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $36,696,100 and increase the dollar amount for fiscal year 2022–23 by $39,581,700 for the purpose of increasing the total hospital access payments under the Medical Assistance program.

37. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $547,500 and increase the dollar amount for fiscal year 2022–23 by $590,700 for the purpose of increasing critical access hospital access payments under the Medical Assistance program.

38. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $883,800 and increase the dollar amount for fiscal year 2022–23 by $5,302,500 for a 20 percent increase to reimbursement rates for outpatient mental health and substance abuse services on each of January 1, 2022, and January 1, 2023.

39. Page 140, line 19: increase the dollar amount for fiscal year 2022–23 by $534,200 for the purpose of increasing by 20 percent the reimbursement rates for child and adolescent day treatment services on January 1, 2023.

40. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $500,000 and increase the dollar amount for fiscal year 2022–23 by $7,260,000 for the purpose of extending Medical Assistance benefits for postpartum women as described in this act.

41. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $1,950,200 and increase the dollar amount for fiscal year 2022–23 by $2,103,100 for the purpose of supplemental payments to hospitals that are freestanding pediatric teaching hospitals located in Wisconsin for which 45 percent or more of their total inpatient days are for Medical Assistance recipients.

42. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $3,274,600 and increase the dollar amount for fiscal year 2022–23 by $3,274,600 for the purpose of providing coverage for room and board costs of Medical Assistance enrollees receiving residential treatment for substance use disorders.

43. Page 140, line 19: increase the dollar amount for fiscal year 2022–23 by $803,200 for the purpose of expanding access to Medical Assistance psychosocial services through the use of non–county providers.

44. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $500,000 and increase the dollar amount for fiscal year 2022–23 by $10,014,000 for the purpose of providing a new Medical Assistance benefit, subject to federal approval, for nonmedical services that contribute to determinants of health.

45. Page 140, line 19: increase the dollar amount for fiscal year 2022–23 by $5,701,600 for the purpose of funding coverage of community health worker services under the Medical Assistance program.

46. Page 140, line 19: increase the dollar amount for fiscal year 2022–23 by $406,700 for the purpose of providing coverage of doula services under the Medical Assistance program.

47. Page 140, line 19: decrease the dollar amount for fiscal year 2021–22 by $1,393,300 and decrease the dollar amount for fiscal year 2022–23 by $2,786,600 for the purpose of increasing reimbursement rates for dental providers that meet quality of care standards, as established by the department of health services, and meet other criteria established under s. 49.45 (24L).

48. Page 140, line 19: increase the dollar amount for fiscal year 2021–22 by $3,080,900 and increase the dollar amount for fiscal year 2022–23 by $6,161,700 for the purpose of increasing reimbursement rates for behavioral health treatment services related to autism under the Medical Assistance program by 25 percent, effective January 1, 2022.

49. Page 140, line 19: increase the dollar amount for fiscal year 2022–23 by $1,281,900 for the purpose of providing reimbursement under the Medical Assistance program, subject to federal approval, for acupuncture services provided by a certified acupuncturist.

50. Page 141, line 2: after that line insert:

"(bh) Behavioral health technology grants GPR A –0– 2,000,000".

51. Page 141, line 7: increase the dollar amount for fiscal year 2021–22 by $5,025,300 and increase the dollar amount for fiscal year 2022–23 by $5,983,000 for the purpose of increasing funding for contractual services and systems costs for the administration of the Medical Assistance and FoodShare programs.

52. Page 141, line 8: increase the dollar amount for fiscal year 2021–22 by $1,445,300 and increase the dollar amount for fiscal year 2022–23 by $2,117,000 for the purpose of funding projected workload increases for income maintenance consortia and tribal income maintenance agencies in the 2021–23 biennium.

53. Page 141, line 10: increase the dollar amount for fiscal year 2022–23 by $4,027,400 for the FoodShare employment and training program.

54. Page 141, line 15: increase the dollar amount for fiscal year 2021–22 by $187,500 and increase the dollar amount for fiscal year 2022–23 by $612,500 for the FoodShare healthy eating incentives and benefit and card processing equipment for farmers markets and direct–marketing farmers as described in this act.

55. Page 144, line 16: decrease the dollar amount for fiscal year 2021–22 by $36,696,100 and decrease the dollar amount for fiscal year 2022–23 by $39,581,700 for the purpose of hospital access payments.

56. Page 144, line 16: decrease the dollar amount for fiscal year 2021–22 by $547,500 and decrease the dollar amount for fiscal year 2022–23 by $590,700 for the purpose of critical access hospital payments.

57. Page 144, line 24: increase the dollar amount for fiscal year 2021–22 by $36,696,100 and increase the dollar amount for fiscal year 2022–23 by $39,581,700 for the purpose of hospital access payments.

58. Page 145, line 3: increase the dollar amount for fiscal year 2021–22 by $547,500 and increase the dollar amount for fiscal year 2022–23 by $590,700 for the purpose of critical access hospital payments.

59. Page 145, line 6: increase the dollar amount for fiscal year 2022–23 by $300,000 for the purpose of developing a substance use disorder treatment platform.

60. Page 145, line 7: increase the dollar amount for fiscal year 2021–22 by $750,000 and increase the dollar amount for fiscal year 2022–23 by $1,250,000 for medication–assisted treatment expansion grants and substance use harm reduction grants as described in this act.

61. Page 145, line 7: increase the dollar amount for fiscal year 2022–23 by $1,936,000 for the purpose of providing behavioral health treatment services for individuals who are deaf, hard of hearing, or deaf–blind.

62. Page 145, line 7: increase the dollar amount for fiscal year 2021–22 by $450,000 and increase the dollar amount for fiscal year 2022–23 by $450,000 for the purpose of an annual grant to the Milwaukee trauma response team.

63. Page 145, line 7: increase the dollar amount for fiscal year 2021–22 by $313,800 and increase the dollar amount for fiscal year 2022–23 by $313,800 for the purpose of supporting a supplemental telephone service to provide backup to staff at peer–run respite centers.

64. Page 145, line 12: after that line insert:

"(bh) Training for methamphetamine addiction treatment GPR A 150,000 300,000".

65. Page 145, line 14: increase the dollar amount for fiscal year 2021–22 by $500,000 for the child psychiatry consultation program.

66. Page 145, line 20: increase the dollar amount for fiscal year 2021–22 by $1,250,000 and increase the dollar amount for fiscal year 2022–23 by $1,250,000 for the purpose of crisis program enhancement grants to establish and enhance law enforcement and behavioral health services emergency response collaboration teams.

67. Page 145, line 20: increase the dollar amount for fiscal year 2021–22 by $850,000 and increase the dollar amount for fiscal year 2022–23 by $850,000 for the purpose of a grant each fiscal year to a county with a population of more than 750,000 to enhance mobile crisis teams.

68. Page 145, line 20: after that line insert:

"(ch)	Crisis response grants	GPR	A	130,500	17,465,600
(cj)	County crisis call center support grants	GPR	A	923,600	923,600".

69. Page 149, line 4: increase the dollar amount for fiscal year 2021–22 by $250,000 and increase the dollar amount for fiscal year 2022–23 by $250,000 for the Alzheimer's family and caregiver support program.

70. Page 149, line 4: increase the dollar amount for fiscal year 2021–22 by $60,000 for the purpose of conducting a one–year tailored caregiver assessment and referral pilot program.

71. Page 149, line 4: increase the dollar amount for fiscal year 2021–22 by $2,395,000 and increase the dollar amount for fiscal year 2022–23 by $4,573,000 for the purpose of expanding services at the aging and disability resource centers.

72. Page 149, line 8: increase the dollar amount for fiscal year 2021–22 by $3,300,000 and increase the dollar amount for fiscal year 2022–23 by $6,600,000 for the purpose of expanding eligibility for services provided under the Birth to 3 program as provided under s. 51.44 (5) (bm).

73. Page 230, line 3: decrease the dollar amount for fiscal year 2021–22 by $5,827,600 and decrease the dollar amount for fiscal year 2022–23 by $5,827,600 for the purpose of paying anticipated overtime costs at care and treatment residential facilities owned by the department of health services from an appropriation to the department of health services.

74. Page 230, line 3: decrease the dollar amount for fiscal year 2021–22 by $650,000 and decrease the dollar amount for fiscal year 2022–23 by $1,600,000 for the purpose of paying for medication–assisted treatment expansion grants, methamphetamine addiction treatment grants, and a substance use disorder treatment platform from appropriations to the department of health services.

75. Page 230, line 3: decrease the dollar amount for fiscal year 2022–23 by $4,027,400 for the purpose of paying for the FoodShare employment and training program from an appropriation to the department of health services.

76. Page 230, line 5: decrease the dollar amount for fiscal year 2021–22 by $3,351,800 and decrease the dollar amount for fiscal year 2022–23 by $3,351,800 for the purpose of paying anticipated overtime costs at care and treatment residential

facilities owned by the department of health services from an appropriation to the department of health services.

77. Page 240, line 17: after that line insert:

"**SECTION 27m.** 20.145 (1) (a) of the statutes is created to read:

20.145 **(1)** (a) *State operations.* The amounts in the schedule for general program operations.

SECTION 27r. 20.145 (1) (g) (intro.) of the statutes is amended to read:

20.145 **(1)** (g) *General program operations.* (intro.) The amounts in the schedule for general program operations, including organizational support services and oversight of care management organizations, development of a public option health insurance plan, and operation of a state–based exchange under s. 601.59, and for transferring to the appropriation account under s. 20.435 (4) (kv) the amount allocated by the commissioner of insurance. Notwithstanding s. 20.001 (3) (a), at the end of each fiscal year, the unencumbered balance in this appropriation account that exceeds 10 percent of that fiscal year's expenditure under this appropriation shall lapse to the general fund. All of the following shall be credited to this appropriation account:

SECTION 27t. 20.145 (1) (g) 5. of the statutes is created to read:

20.145 **(1)** (g) 5. All moneys received under s. 601.59.".

78. Page 247, line 1: after that line insert:

"**SECTION 61g.** 20.435 (1) (cd) of the statutes is created to read:

20.435 **(1)** (cd) *Spinal cord injury research.* A sum sufficient not to exceed $3,000,000 for grants and symposia under s. 255.45 (2) and (3).

SECTION 61m. 20.435 (1) (cr) of the statutes is amended to read:

20.435 **(1)** (cr) *Minority health grants.* The amounts in the schedule for the minority health program under s. 250.20 (3) and (4), for the Black women's health grants under s. 250.20 (7), and for the infant and maternal mortality grants under s. 250.20 (8).".

79. Page 247, line 10: delete the material beginning with that line and ending with page 248, line 3, and substitute:

"**SECTION 65.** 20.435 (4) (b) of the statutes is amended to read:

20.435 **(4)** (b) *Medical Assistance program benefits.* Biennially, the amounts in the schedule to provide a portion of the state share of Medical Assistance program benefits administered under subch. IV of ch. 49, for a portion of the Badger Care health care program under s. 49.665, to provide a portion of the Medical Assistance program benefits administered under subch. IV of ch. 49 that are not also provided under par. (o), to provide payments to federally recognized American Indian tribes or bands in this state under and for the administration of s. 49.45 (5g), to provide a portion of the facility payments under 1999 Wisconsin Act 9, section 9123 (9m), to fund services provided by resource centers under s. 46.283, for services under the family care benefit under s. 46.284 (5), for the community options program under s. 46.27, 2017 stats., for assisting victims of diseases, as provided in ss. 49.68, 49.683, and 49.685, and for reduction of any operating deficits as specified in 2005 Wisconsin Act 15, section 3. Notwithstanding s. 20.002 (1), the department may transfer from this appropriation account to the appropriation account under sub. (5) (kc) funds in the amount of and for the purposes specified in s. 46.485. Notwithstanding ss. 20.001 (3) (b) and 20.002 (1), the department may credit or deposit into this appropriation

account and may transfer between fiscal years funds that it transfers from the appropriation account under sub. (5) (kc) for the purposes specified in s. 46.485 (3r).".

80. Page 248, line 3: after that line insert:

"**SECTION 65d.** 20.435 (4) (bh) of the statutes is created to read:

20.435 **(4)** (bh) *Behavioral health technology grants.* The amounts in the schedule to provide grants to behavioral health providers to implement electronic health records systems and connect to health information exchanges.

SECTION 65f. 20.435 (4) (bq) of the statutes is repealed.

SECTION 65h. 20.435 (4) (bt) of the statutes is amended to read:

20.435 **(4)** (bt) *Healthy eating ~~incentive pilot program~~ incentives.* As a continuing appropriation, the amounts in the schedule to contract with an entity to administer the healthy eating incentive program under s. 49.79 (7r)~~. No moneys may be expended under this paragraph after December 31, 2019, except for moneys encumbered on or before that date~~ and to provide electronic benefit transfer and credit and debit card processing equipment and services to farmers markets and farmers who sell directly to consumers.

SECTION 65k. 20.435 (4) (jw) of the statutes is amended to read:

20.435 **(4)** (jw) *BadgerCare Plus and hospital assessment.* All ~~moneys received from payment of enrollment fees under the program under s. 49.45 (23), all~~ moneys transferred under s. 50.38 (9), all moneys transferred from the appropriation account under par. (jz), and 10 percent of all moneys received from penalty assessments under s. 49.471 (9) (c), ~~for administration of the program under s. 49.45 (23),~~ to provide a portion of the state share of administrative costs for the BadgerCare Plus

Medical Assistance program under s. 49.471, and for administration of the hospital assessment under s. 50.38.

SECTION 65n. 20.435 (5) (bh) of the statutes is created to read:

20.435 **(5)** (bh) *Training for methamphetamine addiction treatment.* The amounts in the schedule for grants to provide trainings to substance use disorder treatment providers on treatment models for methamphetamine addiction.

SECTION 65p. 20.435 (5) (ch) of the statutes is created to read:

20.435 **(5)** (ch) *Crisis response grants.* The amounts in the schedule for grants for crisis response under s. 51.035.

SECTION 65s. 20.435 (5) (cj) of the statutes is created to read:

20.435 **(5)** (cj) *County crisis call center support grants.* The amounts in the schedule for awarding grants for county crisis call center support under s. 46.537.".

81. Page 278, line 15: after that line insert:

"**SECTION 180d.** 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.862, 632.867, 632.87 (3) to (6), 632.871, 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 180e. 40.51 (8) of the statutes, as affected by 2021 Wisconsin Act .... (this act), section 180d, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.728, 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85,

632.853, 632.855, 632.862, 632.867, 632.87 (3) to (6), 632.871, 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 180g. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.862, 632.867, 632.871, 632.885, 632.89, and 632.895 (11) to (17).

SECTION 180h. 40.51 (8m) of the statutes, as affected by 2021 Wisconsin Act .... (this act), section 180g, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.728, 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.862, 632.867, 632.871, 632.885, 632.89, and 632.895 ~~(11)~~ (8) and (10) to (17).".

82. Page 281, line 16: delete "$2,808,900" and substitute "$3,058,900".

83. Page 281, line 17: after that line insert:

"**SECTION 190d.** 46.48 (3m) of the statutes is created to read:

46.48 **(3m)** DEAF, HARD OF HEARING, AND DEAF-BLIND BEHAVIORAL HEALTH TREATMENT CENTER. The department may distribute not more than $1,936,000 in each fiscal year, beginning in fiscal year 2022–23, to a statewide provider of behavioral health treatment services for individuals who are deaf, hard of hearing, or deaf–blind.

SECTION 190f. 46.48 (6) of the statutes is created to read:

46.48 **(6)** TRAUMA RESPONSE TEAMS. The department shall annually award a grant equal to $450,000 for the Milwaukee trauma response team. Notwithstanding

sub. (1), grants awarded under this subsection shall be from the appropriation under s. 20.435 (5) (bc).

SECTION 190f. 46.48 (7) of the statutes is created to read:

46.48 **(7)** MEDICATION-ASSISTED TREATMENT GRANTS. The department shall award up to $500,000 in fiscal year 2021–22 and up to $1,000,000 annually thereafter to develop or support entities that offer medication–assisted treatment. Notwithstanding sub. (1), grants awarded under this subsection shall be from the appropriation under s. 20.435 (5) (bc).

SECTION 190h. 46.48 (9) of the statutes is created to read:

46.48 **(9)** SUBSTANCE USE HARM REDUCTION GRANT. The department may annually award up to $250,000 to organizations with comprehensive harm reduction strategies for the development or support of substance use harm reduction programs, as determined by the department. Notwithstanding sub. (1), grants awarded under this subsection shall be from the appropriation under s. 20.435 (5) (bc).".

84. Page 281, line 23: after that line insert:

"**SECTION 191c.** 46.536 of the statutes is renumbered 46.536 (intro.) and amended to read:

46.536 Crisis program enhancement grants. (intro.) From the appropriation under s. 20.435 (5) (cf), the department shall award all of the following grants:

(1) A ~~in the~~ total amount of $250,000 in each fiscal biennium to counties or regions comprised of multiple counties to establish or enhance crisis programs to serve individuals having crises in rural areas. The department shall award a grant

under this ~~section~~ subsection in an amount equal to one–half the amount of money the county or region provides to establish or enhance crisis programs.

SECTION 191e. 46.536 (2) of the statutes is created to read:

46.536 **(2)** At least $1,250,000 in each fiscal year to establish and enhance law enforcement and behavioral health services emergency response collaboration programs. Grant recipients under this subsection shall match at least 25 percent of the grant amount awarded for the purpose that the grant is received.

SECTION 191g. 46.536 (3) of the statutes is created to read:

46.536 **(3)** At least $850,000 in each fiscal year to a county with a population of more than 750,000 to enhance mobile crisis teams.

SECTION 191j. 46.537 of the statutes is created to read:

46.537 COUNTY CRISIS CALL CENTER SUPPORT GRANTS. From the appropriation under s. 20.435 (5) (cj), the department shall award grants to support mental health professionals to provide supervision and consultation to individuals who support crisis call center services. Each county or multicounty program that receives supervision and consultation services from a grant recipient described under this section shall contribute at least 10 percent of the costs of the services that the grant recipient incurs for the purpose that the grant is received.

SECTION 191k. 46.87 (5m) of the statutes is amended to read:

46.87 **(5m)** A person is financially eligible for the program under this section if the joint income of the person with Alzheimer's disease and that person's spouse, if any, is ~~$48,000~~ $55,000 per year or less, unless the department sets a higher limitation on income eligibility by rule. In determining joint income for purposes of this subsection, the administering agency shall subtract any expenses attributable

to the Alzheimer's–related needs of the person with Alzheimer's disease or of the person's caregiver.

SECTION 191m. 46.977 (1) (intro.) and (a) of the statutes are consolidated, renumbered 46.977 (1) and amended to read:

46.977 **(1)** ~~DEFINITIONS~~ DEFINITION. In this section~~: (a) "Guardian"~~, "guardian" has the meaning given in s. 54.01 (10).

SECTION 191p. 46.977 (1) (b) of the statutes is renumbered 46.977 (2) (ag) and amended to read:

46.977 **(2)** (ag) ~~"Organization"~~ In this subsection, "organization" means a private, nonprofit agency or a county department under s. 46.215, 46.22, 46.23, 51.42 or 51.437.

SECTION 191r. 46.977 (2) (a) of the statutes is renumbered 46.977 (2) (am) and amended to read:

46.977 **(2)** (am) From the appropriation under s. 20.435 (1) (cg), the department may under this ~~section~~ subsection, based on the criteria under par. (c), award grants to applying organizations for the purpose of training and assisting guardians for individuals found incompetent under ch. 54. No grant may be paid unless the awardee provides matching funds equal to 10 percent of the amount of the award.

SECTION 191s. 46.977 (2) (b) (intro.) of the statutes is amended to read:

46.977 **(2)** (b) (intro.) Organizations awarded grants under par. ~~(a)~~ (am) shall do all of the following:

SECTION 191u. 46.977 (2) (c) of the statutes is amended to read:

46.977 **(2)** (c) In reviewing applications for grants under par. (am), the department shall consider the extent to which the proposed program will effectively train and assist guardians for individuals found incompetent under ch. 54.

SECTION 191w. 46.977 (3) of the statutes is created to read:

46.977 **(3)** GRANT FOR INITIAL TRAINING. (a) The department shall award a grant to develop, administer, and conduct the guardian training required under s. 54.26.

(b) The department shall require the grantee to have expertise in state guardianship law, experience with technical assistance and support to guardians and wards, and knowledge of common challenges and questions encountered by guardians and wards.

(c) The grantee selected to develop training that meets the requirements under s. 54.26 (1) shall develop plain–language, web–based training modules using adult–learning design principles that can be accessed for free by training topic and in formats that maximize accessibility, with printed versions available for free upon request.

SECTION 191y. 46.995 (4) of the statutes is created to read:

46.995 **(4)** The department shall ensure that any child who is eligible and who applies for the disabled children's long–term support program that is operating under a waiver of federal law receives services under the disabled children's long–term support program that is operating under a waiver of federal law.".

85. Page 290, line 22: after that line insert:

"**SECTION 226g.** 49.45 (2p) of the statutes is repealed.

SECTION 226m. 49.45 (3) (e) 11. of the statutes is amended to read:

49.45 **(3)** (e) 11. The department shall use a portion of the moneys collected under s. 50.38 (2) (a) to pay for services provided by eligible hospitals, as defined in s. 50.38 (1), other than critical access hospitals, under the Medical Assistance Program under this subchapter, including services reimbursed on a fee–for–service

basis and services provided under a managed care system. For state fiscal year 2008–09, total payments required under this subdivision, including both the federal and state share of Medical Assistance, shall equal the amount collected under s. 50.38 (2) (a) for fiscal year 2008–09 divided by 57.75 percent. For each state fiscal year after state fiscal year 2008–09, total payments required under this subdivision, including both the federal and state share of Medical Assistance, shall equal the amount collected under s. 50.38 (2) (a) for the fiscal year divided by 61.68 percent, except that if the department has expanded eligibility under section 2001 (a) (1) (C) of the Patient Protection and Affordable Care Act, P.L. 111–148, for the Medical Assistance program under this subchapter, the amount collected for the fiscal year shall be divided by 53.69 percent.

SECTION 226r. 49.45 (3) (e) 12. of the statutes is amended to read:

49.45 **(3)** (e) 12. The department shall use a portion of the moneys collected under s. 50.38 (2) (b) to pay for services provided by critical access hospitals under the Medical Assistance Program under this subchapter, including services reimbursed on a fee–for–service basis and services provided under a managed care system. For each state fiscal year, total payments required under this subdivision, including both the federal and state share of Medical Assistance, shall equal the amount collected under s. 50.38 (2) (b) for the fiscal year divided by 61.68 percent, except that if the department has expanded eligibility under section 2001 (a) (1) (C) of the Patient Protection and Affordable Care Act, P.L. 111–148, for the Medical Assistance program under this subchapter, the amount collected for the fiscal year shall be divided by 53.69 percent.".

86. Page 291, line 7: delete lines 7 to 10 and substitute:

"49.45 **(3m)** (b) 3. a. No single hospital receives more than ~~$4,600,000~~ $7,950,000, except that in the 2021–23 fiscal biennium the department may increase proportionately the maximum a single hospital may receive if the state is eligible for an enhanced federal medical assistance percentage under federal law.".

87. Page 291, line 11: delete the material beginning with that line and ending with page 292, line 12, and substitute:

"**SECTION 229.** 49.45 (5g) of the statutes is created to read:

49.45 **(5g)** PAYMENTS TO TRIBES. (a) *Tribal care coordination agreements*. A tribal health care provider's care coordination agreement with a nontribal health care provider shall meet federal requirements, including that a service provided by the nontribal health care provider be at the request of the tribal health care provider on behalf of a tribal member who remains in the tribal health care provider's care according to the care coordination agreement; that both the tribal health care provider and nontribal health care provider are providers, as defined in s. 49.43 (10); that an established relationship exists between the tribal health care provider and the tribal member; and that the care be provided pursuant to a written care coordination agreement.

(b) *Amount and distribution of payments*. 1. From the appropriation account under s. 20.435 (4) (b), the department shall make payments to eligible governing bodies of federally recognized American Indian tribes or bands or tribal health care providers in an amount and manner determined by the department. The department shall determine payment amounts on the basis of the difference between the state share of medical assistance payments paid for services rendered to tribal members for whom a care coordination agreement with nontribal health care

providers is in place and the state share of medical assistance payments that would have been paid for those services absent a care coordination agreement with nontribal partners.

2. The department shall withhold from the payments under subd. 1. the state share of administrative costs associated with carrying out this subsection, not to exceed 10 percent of the amounts calculated in subd. 1.

3. Federally recognized American Indian tribes or bands may use funds paid under this subsection for health–related purposes. The department shall consult biennially with tribes to determine the timing and distribution of payments.".

88. Page 292, line 12: after that line insert:

"**SECTION 229c.** 49.45 (6xm) of the statutes is created to read:

49.45 **(6xm)** PEDIATRIC INPATIENT SUPPLEMENT. (a) From the appropriations under s. 20.435 (4) (b), (o), and (w), the department shall, using a method determined by the department, distribute a total sum of $2,000,000 each state fiscal year to hospitals that meet all of the following criteria:

1. The hospital is an acute care hospital located in this state.

2. During the hospital's fiscal year, the inpatient days in the hospital's acute care pediatric units and intensive care pediatric units totaled more than 12,000 days, not including neonatal intensive care units. For purposes of this subsection, the hospital's fiscal year is the hospital's fiscal year that ended in the 2nd calendar year preceding the beginning of the state fiscal year.

(b) Notwithstanding par. (a), from the appropriations under s. 20.435 (4) (b), (o), and (w), if the department has expanded eligibility under section 2001 (a) (1) (C) of the Patient Protection and Affordable Care Act, P.L. 111–148, for the Medical

Assistance program under this subchapter, then the department may, using a method determined by the department, distribute an additional total sum of $7,500,000 in each state fiscal year to hospitals that are free–standing pediatric teaching hospitals located in Wisconsin that have a percentage calculated under s. 49.45 (3m) (b) 1. a. greater than 45 percent.

SECTION 229d. 49.45 (23) of the statutes is repealed.

SECTION 229f. 49.45 (23b) (title) of the statutes is amended to read:

49.45 **(23b)** (title) CHILDLESS ADULTS ~~DEMONSTRATION PROJECT~~ REFORM WAIVER IMPLEMENTATION REQUIRED.

SECTION 229g. 49.45 (23b) (b) of the statutes is amended to read:

49.45 **(23b)** (b) Beginning as soon as practicable after October 31, 2018, and ending no sooner than December 31, 2023, the department shall do all of the following with regard to ~~the~~ childless adults ~~demonstration project~~ under ~~sub. (23)~~ s. 49.471 (4) (a) 8.:

1. Require in each month persons, except exempt individuals, who are eligible to receive Medical Assistance under ~~sub. (23)~~ s. 49.471 (4) (a) 8. and who are at least 19 years of age but have not attained the age of 50 to participate in, document, and report 80 hours per calendar month of community engagement activities. The department, after finding good cause, may grant a temporary exemption from the requirement under this subdivision upon request of a Medical Assistance recipient.

2. Require persons with incomes of at least 50 percent of the poverty line to pay premiums in accordance with par. (c) as a condition of eligibility for Medical Assistance under ~~sub. (23)~~ s. 49.471 (4) (a) 8.

3. Require as a condition of eligibility for Medical Assistance under ~~sub. (23)~~ s. 49.471 (4) (a) 8. completion of a health risk assessment.

4. Charge recipients of Medical Assistance under ~~sub. (23)~~ s. 49.471 (4) (a) 8. an $8 copayment for nonemergency use of the emergency department in accordance with 42 USC 1396o–1 (e) (1) and 42 CFR 447.54.

5. Disenroll from Medical Assistance under ~~sub. (23)~~ s. 49.471 (4) (a) 8. for 6 months any individual who does not pay a required premium under subd. 2. and any individual who is required under subd. 1. to participate in a community engagement activity but who does not participate for 48 aggregate months in the community engagement activity.

SECTION 229h. 49.45 (23b) (c) of the statutes is amended to read:

49.45 **(23b)** (c) 1. Persons who are eligible ~~for the demonstration project~~ under ~~sub. (23)~~ s. 49.471 (4) (a) 8. and who have monthly household income that exceeds 50 percent of the poverty line shall pay a monthly premium amount of $8 per household. A person who is eligible to receive an item or service furnished by an Indian health care provider is exempt from the premium requirement under this subdivision.

2. The department may disenroll under par. (b) 5. a person for nonpayment of a required monthly premium only at annual eligibility redetermination after providing notice and reasonable opportunity for the person to pay. If a person who is disenrolled for nonpayment of premiums pays all owed premiums or becomes exempt from payment of premiums, he or she may reenroll in Medical Assistance under ~~sub. (23)~~ s. 49.471 (4) (a) 8.

3. The department shall reduce the amount of the required household premium by up to half for a recipient of Medical Assistance under ~~sub. (23)~~ s. 49.471 (4) (a) 8. who does not engage in certain behaviors that increase health risks or who attests to actively managing certain unhealthy behaviors.

SECTION 229j. 49.45 (23b) (e) of the statutes is amended to read:

49.45 **(23b)** (e) Before December 31, 2023, the ~~demonstration project~~ requirements under this subsection may not be withdrawn and the department may not request from the federal government withdrawal, suspension, or termination of the ~~demonstration project~~ requirements under this subsection unless legislation has been enacted specifically allowing for the withdrawal, suspension, or termination.

SECTION 229m. 49.45 (24L) of the statutes is created to read:

49.45 **(24L)** CRITICAL ACCESS REIMBURSEMENT PAYMENTS TO DENTAL PROVIDERS. (a) Based on the criteria in pars. (b) and (c), the department shall increase reimbursements to dental providers that meet quality of care standards, as established by the department.

(b) In order to be eligible for enhanced reimbursement under this subsection, the provider must meet one of the following qualifications:

1. For a nonprofit or public provider, 50 percent or more of the individuals served by the provider are individuals who are without dental insurance or are enrolled in the Medical Assistance program.

2. For a for–profit provider, 5 percent or more of the individuals served by the provider are enrolled in the Medical Assistance program.

(c) For dental services rendered on or after January 1, 2022, by a qualified nonprofit or public dental provider, the department shall increase reimbursement by 50 percent above the reimbursement rate that would otherwise be paid to that provider. For dental services rendered on or after January 1, 2022, by a qualified for–profit dental provider, the department shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to that provider. For dental providers rendering services to individuals in managed care under the

Medical Assistance program, for services rendered on or after January 1, 2022, the department shall increase reimbursement to pay an additional amount on the basis of the rate that would have been paid to the dental provider had the individual not been enrolled in managed care.

(d) If a provider has more than one service location, the thresholds described under par. (b) apply to each location, and the department will determine the payment for each separate service location.

(e) Any provider that receives reimbursement through the pilot project under sub. (24k) is not eligible for reimbursement under this subsection.

SECTION 229p. 49.45 (25r) of the statutes is created to read:

49.45 **(25r)** COMMUNITY HEALTH WORKER SERVICES. (a) In this subsection:

1. "Community health services" means services provided by a community health worker.

2. "Community health worker" means a front–line public health worker who is a trusted member of or has a close understanding of the community served, enabling the worker to serve as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery, and who builds individual and community capacity by increasing health knowledge and self–sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

(b) The department shall request any necessary waiver from, or submit any necessary amendments to the state Medical Assistance plan to, the secretary of the federal department of health and human services to provide community health services to eligible Medical Assistance recipients. If the waiver or state plan

amendment is granted, the department shall reimburse certified providers for those community health services approved by the federal department of health and human services for Medical Assistance coverage and as provided to Medical Assistance recipients under s. 49.46 (2) (b) 9m.

SECTION 229r. 49.45 (30e) (a) 2. of the statutes is repealed.

SECTION 229s. 49.45 (30e) (b) 3. of the statutes is amended to read:

49.45 **(30e)** (b) 3. Requirements for certification of community–based psychosocial service programs. The department may certify county–based providers and providers that are not county–based providers.

SECTION 229t. 49.45 (30e) (c) of the statutes is renumbered 49.45 (30e) (c) 1. and amended to read:

49.45 **(30e)** (c) 1. ~~A~~ The department shall reimburse a county that elects to ~~make the~~ provide services under s. 49.46 (2) (b) 6. Lm. ~~available shall reimburse a provider of the services~~ for the amount of the allowable charges for those services under the ~~medical assistance~~ Medical Assistance program that is not provided by the federal government~~. The department shall reimburse the provider only for~~ and the amount of the allowable charges for those services under the ~~medical assistance~~ Medical Assistance program that is provided by the federal government.

SECTION 229u. 49.45 (30e) (c) 2. of the statutes is created to read:

49.45 **(30e)** (c) 2. The department shall reimburse to a provider that is not a county–based provider for services under s. 49.46 (2) (b) 6. Lm. for both the federal and nonfederal share of a fee schedule that is determined by the department.

SECTION 229v. 49.45 (30e) (d) of the statutes is amended to read:

49.45 **(30e)** (d) *Provision of services on regional basis.* Notwithstanding par. (c) 1. and subject to par. (e), in counties that elect to ~~deliver~~ provide the services under

s. 49.46 (2) (b) 6. Lm. through the Medical Assistance program on a regional basis according to criteria established by the department, the department shall reimburse a provider of the services for the amount of the allowable charges for those services under the Medical Assistance program that is provided by the federal government and for the amount of the allowable charges that is not provided by the federal government.

SECTION 229x. 49.45 (30t) of the statutes is created to read:

49.45 **(30t)** DOULA SERVICES. (a) In this subsection:

1. "Certified doula" means an individual who has received certification from a doula certifying organization recognized by the department.

2. "Doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and the postpartum period.

(b) The department shall request from the secretary of the federal department of health and human services any required waiver or any required amendment to the state plan for Medical Assistance to allow reimbursement for doula services provided by a certified doula. If the waiver or state plan amendment is granted, the department shall reimburse a certified doula under s. 49.46 (2) (b) 12p. for the allowable charges for doula services provided to Medical Assistance recipients.".

89. Page 292, line 13: delete the material beginning with that line and ending with page 294, line 2, and substitute:

"**SECTION 230b.** 49.46 (1) (a) 1m. of the statutes is amended to read:

49.46 **(1)** (a) 1m. Any pregnant woman whose income does not exceed the standard of need under s. 49.19 (11) and whose pregnancy is medically verified.

Eligibility continues to the last day of the month in which the ~~60th~~ 365th day after the last day of the pregnancy falls.

SECTION 230d. 49.46 (1) (j) of the statutes is amended to read:

49.46 **(1)** (j) An individual determined to be eligible for benefits under par. (a) 9. remains eligible for benefits under par. (a) 9. for the balance of the pregnancy and to the last day of the month in which the ~~60th~~ 365th day after the last day of the pregnancy falls without regard to any change in the individual's family income.

SECTION 230f. 49.46 (2) (b) 8m. of the statutes is created to read:

49.46 **(2)** (b) 8m. Room and board for residential substance use disorder treatment.

SECTION 230h. 49.46 (2) (b) 9m. of the statutes is created to read:

49.46 **(2)** (b) 9m. Community health services, as specified under s. 49.45 (25r).

SECTION 230j. 49.46 (2) (b) 11m. of the statutes is created to read:

49.46 **(2)** (b) 11m. Subject to par. (bx), acupuncture provided by an acupuncturist who holds a certificate under ch. 451.

SECTION 230k. 49.46 (2) (b) 12p. of the statutes is created to read:

49.46 **(2)** (b) 12p. Doula services provided by a certified doula, as specified under s. 49.45 (30t).

SECTION 230n. 49.46 (2) (b) 24. of the statutes is created to read:

49.46 **(2)** (b) 24. Subject to par. (bv), nonmedical services that contribute to the determinants of health.

SECTION 230p. 49.46 (2) (bv) of the statutes is created to read:

49.46 **(2)** (bv) The department shall determine those services under par. (b) 24. that contribute to the determinants of health. The department shall seek any necessary state plan amendment or request any waiver of federal Medicaid law to

implement this paragraph. The department is not required to provide the services under this paragraph as a benefit under the Medical Assistance program if the federal department of health and human services does not provide federal financial participation for the services under this paragraph.

SECTION 230r. 49.46 (2) (bx) of the statutes is created to read:

49.46 **(2)** (bx) The department shall submit to the federal department of health and human services any request for a state plan amendment, waiver, or other federal approval necessary to provide reimbursement for the benefit under par. (b) 11m. If the federal department approves the request or if no federal approval is necessary, the department shall provide the benefit and reimbursement under par. (b) 11m. If the federal department disapproves the request, the department may not provide the benefit or reimbursement for the benefit described under par. (b) 11m.

SECTION 230u. 49.47 (4) (ag) 2. of the statutes is amended to read:

49.47 **(4)** (ag) 2. Pregnant and the woman's pregnancy is medically verified Eligibility continues to the last day of the month in which the ~~60th~~ 365th day after the last day of the pregnancy falls.

SECTION 231b. 49.471 (1) (cr) of the statutes is created to read:

49.471 **(1)** (cr) "Enhanced federal medical assistance percentage" means a federal medical assistance percentage described under 42 USC 1396d (y) or (z).

SECTION 231d. 49.471 (4) (a) 4. b. of the statutes is amended to read:

49.471 **(4)** (a) 4. b. The individual's family income does not exceed ~~100~~ 133 percent of the poverty line ~~before application of the 5 percent income disregard under 42 CFR 435.603 (d)~~.

SECTION 231f. 49.471 (4) (a) 8. of the statutes is created to read:

49.471 **(4)** (a) 8. An individual who meets all of the following criteria:

a. The individual is an adult under the age of 65.

b. The individual has a family income that does not exceed 133 percent of the poverty line, except as provided in sub. (4g).

c. The individual is not otherwise eligible for the Medical Assistance program under this subchapter or the Medicare program under 42 USC 1395 et seq.

SECTION 231j. 49.471 (4g) of the statutes is created to read:

49.471 **(4g)** MEDICAID EXPANSION; FEDERAL MEDICAL ASSISTANCE PERCENTAGE. For services provided to individuals described under sub. (4) (a) 8., the department shall comply with all federal requirements to qualify for the highest available enhanced federal medical assistance percentage. The department shall submit any amendment to the state medical assistance plan, request for a waiver of federal Medicaid law, or other approval request required by the federal government to provide services to the individuals described under sub. (4) (a) 8. and qualify for the highest available enhanced federal medical assistance percentage. Sections 20.940 and 49.45 (2t) do not apply to a submission to the federal government under this subsection.

SECTION 231m. 49.471 (6) (b) of the statutes is amended to read:

49.471 **(6)** (b) A pregnant woman who is determined to be eligible for benefits under sub. (4) remains eligible for benefits under sub. (4) for the balance of the pregnancy and to the last day of the month in which the ~~60th~~ 365th day after the last day of the pregnancy falls without regard to any change in the woman's family income.

SECTION 231p. 49.471 (6) (L) of the statutes is created to read:

49.471 **(6)** (L) The department shall request from the federal department of health and human services approval of a state plan amendment, a waiver of federal

Medicaid law, or approval of a demonstration project to maintain eligibility for postpartum women to the last day of the month in which the 365th day after the last day of the pregnancy falls under ss. 49.46 (1) (a) 1m. and 9. and (j), 49.47 (4) (ag) 2., and 49.471 (4) (a) 1g. and 1m., (6) (b), and (7) (b) 1. The department shall cover and provide reimbursement for services under ss. 49.46 (1) (a) 1m. and 9. and (j), 49.47 (4) (ag) 2., and 49.471 (4) (a) 1g. and 1m., (6) (b), and (7) (b) 1. regardless of whether a state plan amendment, waiver of federal Medicaid law, or approval of a demonstration project related to coverage or reimbursement of these services is granted by the federal department of human services.

SECTION 231t. 49.471 (7) (b) 1. of the statutes is amended to read:

49.471 **(7)** (b) 1. A pregnant woman whose family income exceeds 300 percent of the poverty line may become eligible for coverage under this section if the difference between the pregnant woman's family income and the applicable income limit under sub. (4) (a) is obligated or expended for any member of the pregnant woman's family for medical care or any other type of remedial care recognized under state law or for personal health insurance premiums or for both. Eligibility obtained under this subdivision continues without regard to any change in family income for the balance of the pregnancy and to the last day of the month in which the ~~60th~~ 365th day after the last day of the woman's pregnancy falls. Eligibility obtained by a pregnant woman under this subdivision extends to all pregnant women in the pregnant woman's family.

SECTION 231w. 49.686 (3) (d) of the statutes is amended to read:

49.686 **(3)** (d) Has applied for coverage under and has been denied eligibility for medical assistance within 12 months prior to application for reimbursement under sub. (2). This paragraph does not apply to an individual who is eligible for

benefits under ~~the demonstration project for childless adults under s. 49.45 (23) or to an individual who is eligible for benefits under~~ BadgerCare Plus under s. 49.471 (4) (a) 8. or (11).

SECTION 232d. 49.79 (7r) (d) of the statutes is created to read:

49.79 **(7r)** (d) The department may expend from the appropriation under s. 20.435 (4) (bt) no more than $425,000 per fiscal year for the pilot program under this subsection.

SECTION 232g. 49.79 (9) (a) 1g. of the statutes is amended to read:

49.79 **(9)** (a) 1g. Except as provided in subds. 2. and 3., ~~beginning October 1, 2019,~~ the department shall require, to the extent allowed by the federal government, ~~all~~ able–bodied adults without dependents in this state to participate in the employment and training program under this subsection, except for able–bodied adults without dependents who are employed, as determined by the department. The department may require ~~other~~ able individuals who are 18 to 60 years of age, or a subset of those individuals to the extent allowed by the federal government, who are not participants in a Wisconsin Works employment position to participate in the employment and training program under this subsection.

SECTION 232j. 49.79 (9) (d) of the statutes is repealed.

SECTION 232L. 49.79 (9) (f) of the statutes is repealed.

SECTION 232p. 49.791 of the statutes is repealed.

SECTION 232v. 51.035 of the statutes is created to read:

51.035 Crisis response system; grants. (1) From the appropriation under s. 20.435 (5) (ch), the department shall award grants under this section to entities to provide a continuum of crisis response services, including mental health crisis

urgent care and observation centers, crisis stabilization and inpatient psychiatric beds, and crisis stabilization facilities.

(2) From the appropriation under s. 20.435 (5) (ch), the department shall award no more than 5 grants to fund services at facilities providing crisis stabilization services, based on criteria established by the department.

SECTION 232z. 51.036 of the statutes is created to read:

51.036 Crisis urgent care and observation centers. (1) In this section, "crisis" has the meaning given in s. 51.042 (1) (a).

(2) The department may certify crisis urgent care and observation centers and may establish criteria by rule for the certification of crisis urgent care and observation centers. If the department establishes a certification process for crisis urgent care and observation centers, no person may operate a crisis urgent care and observation center without having a certification. The department may limit the number of certifications it grants to operate crisis urgent care and observation centers.".

90. Page 294, line 8: delete "$80,000" and substitute "~~$80,000~~ $100,000".

91. Page 295, line 17: after that line insert:

"**SECTION 238c.** 51.44 (5) (bm) of the statutes is created to read:

51.44 **(5)** (bm) Ensure that any child with a level of lead in his or her blood that is 5 or more micrograms per 100 milliliters of blood, as confirmed by one venous blood test, is eligible for services under the program under this section.

SECTION 238f. 54.15 (8) (a) (intro.) of the statutes is amended to read:

54.15 **(8)** (a) (intro.) At least 96 hours before the hearing under s. 54.44, the proposed guardian shall submit to the court ~~a~~ all of the following:

1m. A sworn and notarized statement as to whether any of the following is true:

SECTION 238g. 54.15 (8) (a) 1. to 4. of the statutes are renumbered 54.15 (8) (a) 1m. a. to d.

SECTION 238h. 54.15 (8) (a) 2m. of the statutes is created to read:

54.15 **(8)** (a) 2m. A sworn and notarized statement that the proposed guardian has completed the training requirements under s. 54.26 (1), unless exempted under s. 54.26 (2) (c), (d), or (e).

SECTION 238j. 54.15 (8) (b) of the statutes is amended to read:

54.15 **(8)** (b) If par. (a) ~~1., 2., 3., or 4.~~ 1m. a., b., c., or d. applies to the proposed guardian, he or she shall include in the sworn and notarized statement a description of the circumstances surrounding the applicable event under par. (a) ~~1., 2., 3., or 4.~~ 1m. a., b., c., or d.

SECTION 238m. 54.26 of the statutes is created to read:

54.26 Guardian training requirements. (1) REQUIRED TRAINING TOPICS. (a) Every guardian of the person, unless exempted under sub. (2) (c), (d), or (e), shall complete training on all of the following topics:

1. The duties and responsibilities of a guardian of the person under the law and limits of the guardian's decision–making authority.

2. Alternatives to guardianship, including supported decision–making agreements and powers of attorney.

3. Rights retained by a ward.

4. Best practices for a guardian to solicit and understand the wishes and preferences of a ward, to involve a ward in decision making, and to take a ward's wishes and preferences into account in decisions made by the guardian.

5. Restoration of a ward's rights and the process for removal of guardianship.

6. Future planning and identification of a potential standby or successor guardian.

7. Resources and technical support for guardians.

(b) Every guardian of the estate shall complete training on all of the following topics:

1. The duties and responsibilities of a guardian of the estate under the law and limits of the guardian's decision–making authority.

2. Inventory and accounting requirements.

(2) INITIAL TRAINING REQUIREMENTS. (a) Before the final hearing for a permanent guardianship, any person nominated for appointment or seeking appointment as a guardian of the person is required to receive the training required under sub. (1) (a).

(b) Before the final hearing for permanent guardianship, any person nominated for appointment or seeking appointment as a guardian of the estate is required to receive at least the training required under sub. (1) (b).

(c) A guardian under s. 54.15 (7) who is regulated by the department is exempt from pars. (a) and (b).

(d) A volunteer guardian who has completed the training requirements under sub. (1) is exempt from pars. (a) and (b) with regard to subsequent wards.

(e) A guardian of the person or a guardian of the estate, or both, for a minor under s. 54.10 (1) is exempt from pars. (a) and (b).

SECTION 238r. 66.0137 (4) of the statutes is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),

632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.862, 632.867, 632.87 (4) to (6), 632.871, 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 238t. 66.0137 (4) of the statutes, as affected by 2021 Wisconsin Act .... (this act), section 238r, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.729, 632.746 (1) and (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.862, 632.867, 632.87 (4) to (6), 632.871, 632.885, 632.89, 632.895 ~~(9)~~ (8) to (17), 632.896, and 767.513 (4).".

92. Page 301, line 13: after that line insert:

"**SECTION 257m.** 71.07 (8p) of the statutes is created to read:

71.07 **(8p)** FAMILY CAREGIVER TAX CREDIT. (a) *Definitions.* In this subsection:

1. "Claimant" means an individual who files a claim under this subsection for amounts paid for qualified expenses to benefit a qualified family member.

2. "Physician" has the meaning given in s. 36.60 (1) (b).

3. "Qualified expenses" means amounts paid by a claimant in the year to which the claim relates for items that relate directly to the care or support of a qualified family member, including the following:

a. The improvement or alteration of the claimant's primary residence to enable or assist the qualified family member to be mobile, safe, or independent.

b. The purchase or lease of equipment to enable or assist the qualified family member to carry out one or more activities of daily living.

c. The acquisition of goods or services, or support, to assist the claimant in caring for the qualified family member, including employing a home care aide or personal care attendant, adult day care, specialized transportation, legal or financial services, or assistive care technology.

4. "Qualified family member" means an individual to whom all of the following apply:

a. The individual is at least 18 years of age during the taxable year to which the claim relates.

b. The individual requires assistance with one or more daily living activities, as certified in writing by a physician.

c. The individual is the claimant's family member, as defined in s. 46.2805 (6m).

(b) *Filing claims.* For taxable years beginning after December 31, 2020, and subject to the limitations provided in this subsection, a claimant may claim as a credit against the tax imposed under s. 71.02, up to the amount of those taxes, 50 percent of the claimant's qualified expenses.

(c) *Limitations.* 1. Subject to subds. 2. and 3., the maximum credit that may be claimed under this subsection each taxable year with regard to a particular qualified family member is $500 or, if a claimant is married and filing a separate return, $250. If more than one individual may file a claim under this subsection for a particular qualified family member, the maximum credit specified in this subdivision shall be apportioned among all eligible claimants based on the ratio of their qualified expenses to the total amount of all qualified expenses incurred on behalf of that particular qualified family member, as determined by the department.

2. If the claimant is married and filing jointly and the couple's federal adjusted gross income in the taxable year exceeds $170,000, no credit may be claimed under this subsection. If the claimant is married and filing jointly and the couple's federal adjusted gross income in the taxable year exceeds $150,000, but does not exceed $170,000, the credit claimed under this subsection may not exceed the amount determined as follows:

a. Determine the amount allowed under par. (b) without regard to this subdivision but with regard to subd. 1.

b. Subtract $150,000 from the couple's federal adjusted gross income.

c. Divide the amount determined under subd. 2. b. by $20,000.

d. Multiple the amount determined under subd. 2. a. by the amount determined under subd. 2. c.

e. Subtract the amount determined under subd. 2. d. from the amount determined under subd. 2. a.

3. If the claimant files as a single individual or head of household, or is married and files separately, and the claimant's federal adjusted gross income in the taxable year exceeds $85,000, no credit may be claimed under this subsection. If the claimant files as a single individual or head of household, or is married and files separately, and the claimant's federal adjusted gross income in the taxable year exceeds $75,000, but does not exceed $85,000, the credit claimed under this subsection may not exceed the amount determined as follows:

a. Determine the amount allowed under par. (b) without regard to this subdivision but with regard to subd. 1.

b. Subtract $75,000 from the claimant's federal adjusted gross income.

c. Divide the amount determined under subd. 3. b. by $10,000.

d. Multiple the amount determined under subd. 3. a. by the amount determined under subd. 3. c.

e. Subtract the amount determined under subd. 3. d. from the amount determined under subd. 3. a.

4. No credit may be allowed under this subsection unless it is claimed within the period specified under s. 71.75 (2).

5. No credit may be claimed under this subsection by nonresidents or part–year residents of this state.

6. Qualified expenses may not include any of the following:

a. General food, clothing, or transportation expenses.

b. Ordinary household maintenance or repair expenses that are not directly related or necessary for the care of the qualified family member.

c. Any amount that is paid or reimbursed by insurance or other means.

7. No credit may be allowed under this subsection for a taxable year covering a period of less than 12 months, except for a taxable year closed by reason of the death of the taxpayer.

(d) *Administration.* Subsection (9e) (d), to the extent that it applies to the credit under that subsection, applies to the credit under this subsection.".

93. Page 302, line 15: after that line insert:

"**SECTION 259m.** 71.10 (4) (hd) of the statutes is created to read:

71.10 **(4)** (hd) Family caregiver tax credit under s. 71.07 (8p).".

94. Page 337, line 10: after that line insert:

"**SECTION 351k.** 120.13 (2) (g) of the statutes is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.862, 632.867, 632.87 (4) to (6), 632.871, 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 351n. 120.13 (2) (g) of the statutes, as affected by 2021 Wisconsin Act .... (this act), section 351k, is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.729, 632.746 (1) and (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.862, 632.867, 632.87 (4) to (6), 632.871, 632.885, 632.89, 632.895 ~~(9)~~ (8) to (17), 632.896, and 767.513 (4).".

95. Page 340, line 11: after that line insert:

"**SECTION 363k.** 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.729, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.862, 632.867, 632.87 (2) to (6), 632.871, 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 363m. 185.983 (1) (intro.) of the statutes, as affected by 2021 Wisconsin Act ....(this act), section 363k, is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to

646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.728, 632.729, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.862, 632.867, 632.87 (2) to (6), 632.871, 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:".

96. Page 340, line 22: after that line insert:

"**SECTION 365d.** 250.15 (1) of the statutes is renumbered 250.15 (1) (intro.) and amended to read:

250.15 **(1)** ~~DEFINITION~~ DEFINITIONS. (intro.) In this section~~, "community:~~

(a) "Community health center" means a health care entity that provides primary health care, health education and social services to low–income individuals.

SECTION 365f. 250.15 (1) (b) of the statutes is created to read:

250.15 **(1)** (b) "Free and charitable clinics" means health care organizations that use a volunteer and staff model to provide health services to uninsured, underinsured, underserved, economically and socially disadvantaged, and vulnerable populations and that meet all of the following criteria:

1. The organizations are nonprofit and tax exempt or are a part of a larger nonprofit, tax–exempt organization.

2. The organizations are located in this state or serve residents in this state.

3. The organizations restrict eligibility to receive services to individuals who are uninsured, underinsured, or have limited or no access to primary, specialty, or prescription care.

4. The organizations provide one or more of the following services:

a. Medical care.

b. Mental health care.

c. Dental care.

d. Prescription medications.

5. The organizations use volunteer health care professionals, nonclinical volunteers, and partnerships with other health care providers to provide the services under subd. 4.

6. The organizations are not federally–qualified health centers as defined in 42 USC 1396d (l) (2) and do not receive reimbursement from the federal centers for medicare and medicaid services under a federally–qualified health center payment methodology.

SECTION 365j. 250.15 (2) (d) of the statutes is created to read:

250.15 **(2)** (d) To free and charitable clinics, $2,500,000.

SECTION 365m. 250.20 (7) of the statutes is created to read:

250.20 **(7)** BLACK WOMEN'S HEALTH GRANTS. From the appropriation under s. 20.435 (1) (cr), the department shall annually award grants in the total amount of $1,750,000 to community–serving organizations that are led by Black women that improve Black women's health in Dane, Milwaukee, Rock, and Kenosha Counties.

SECTION 365r. 250.20 (8) of the statutes is created to read:

250.20 **(8)** INFANT AND MATERNAL MORTALITY GRANTS. From the appropriation under s. 20.435 (1) (cr), the department shall annually award grants in the total amount of $1,750,000 to organizations that work to reduce racial disparities related to infant and maternal mortality.".

97. Page 340, line 23: delete the material beginning with that line and ending with page 341, line 2, and substitute:

"**SECTION 366.** 254.151 (1m) (g) of the statutes is amended to read:

254.151 **(1m)** (g) In each fiscal year, ~~$125,000~~ $175,000 to fund lead screening and outreach activities at a community–based human service agency that provides primary health care, health education and social services to low–income individuals in 1st class cities.".

98. Page 341, line 2: after that line insert:

"**SECTION 366g.** 255.15 (3) (d) of the statutes is created to read:

255.15 **(3)** (d) From the appropriation under s. 20.435 (1) (fm), the department may develop and implement a public health campaign aimed at the prevention of initiation of tobacco and vapor product use and may award grants for local and regional organizations working on youth vaping and providing cessation services.

SECTION 366m. 255.15 (4) of the statutes is amended to read:

255.15 **(4)** REPORTS. Not later than April 15, ~~2002~~ 2022, and annually thereafter, the department shall submit to the governor and to the chief clerk of each house of the legislature for distribution under s. 13.172 (2) a report that evaluates the success of the ~~grant program~~ programs under sub. (3). The report shall specify the number of grants awarded during the immediately preceding fiscal year and the purpose for which each grant was made. The report shall also specify donations and grants accepted by the department under sub. (5).

SECTION 366r. 255.45 of the statutes is created to read:

255.45 Spinal cord injury research grants and symposia. (1) DEFINITIONS. In this section:

(a) "Council" means the spinal cord injury council.

(b) "Grant program" means the program established under sub. (2).

(2) GRANT PROGRAM. The department shall establish a program to award grants to persons in this state for research into spinal cord injuries. The purpose of the grants is to support research into new and innovative treatments and rehabilitative efforts for the functional improvement of people with spinal cord injuries, and research topics may include pharmaceutical, medical device, brain stimulus, and rehabilitative approaches and techniques. Grant recipients shall agree to present their research findings at symposia held by the department under sub. (3).

(3) SYMPOSIA. The department may hold symposia every 2 years for recipients of grants under the grant program to present findings of research supported by the grants.

(4) GRANT REPORTS. By January 15 of each year, the department shall submit an annual report to the appropriate standing committees of the legislature under s. 13.172 (3) that identifies the recipients of grants under the grant program and the purposes for which the grants were used.

(5) COUNCIL. (a) The council shall do all of the following:

1. Develop criteria for the department to evaluate and award grants under the grant program.

2. Review and make recommendations to the department on applications submitted under the grant program.

3. Perform other duties specified by the department.

(b) Each member of the council shall disclose in a written statement any financial interest in any organization that the council recommends to receive a grant

under the grant program. The council shall include the written statements with its recommendations to the department on grant applications.".

99. Page 354, line 23: after that line insert:

"**SECTION 411d.** 601.41 (13) of the statutes is created to read:

601.41 **(13)** VALUE-BASED DIABETES MEDICATION PILOT PROJECT. The commissioner shall develop a pilot project to direct a pharmacy benefit manager, as defined in s. 632.865 (1) (c), and a pharmaceutical manufacturer to create a value–based, sole–source arrangement to reduce the costs of prescription medication used to treat diabetes. The commissioner may promulgate rules to implement this subsection.

SECTION 411f. 601.415 (14) of the statutes is created to read:

601.415 **(14)** PATIENT PHARMACY BENEFITS TOOL. (a) From the appropriation under s. 20.145 (1) (a), beginning in the 2022–23 fiscal year, the office shall award grants in a total amount of up to $500,000 each fiscal year to health care providers to develop and implement a tool for prescribers to disclose the cost of prescription drugs for patients. The tool must be usable by physicians and other prescribers to determine the cost of prescription drugs for their patients.

(b) Any health care provider that receives a grant under par. (a) shall contribute matching funds equal to at least 50 percent of the grant amount awarded.

SECTION 411h. 601.575 of the statutes is created to read:

601.575 Prescription drug importation program. (1) IMPORTATION PROGRAM REQUIREMENTS. The commissioner, in consultation with persons interested in the sale and pricing of prescription drugs and appropriate officials and agencies of the federal government, shall design and implement a prescription drug

importation program for the benefit of residents of this state, that generates savings for residents, and that satisfies all of the following:

(a) The commissioner shall designate a state agency to become a licensed wholesale distributor or to contract with a licensed wholesale distributor and shall seek federal certification and approval to import prescription drugs.

(b) The prescription drug importation program under this section shall comply with relevant requirements of 21 USC 384, including safety and cost savings requirements.

(c) The prescription drug importation program under this section shall import prescription drugs from Canadian suppliers regulated under any appropriate Canadian or provincial laws.

(d) The prescription drug importation program under this section shall have a process to sample the purity, chemical composition, and potency of imported prescription drugs.

(e) The prescription drug importation program under this section shall import only those prescription drugs for which importation creates substantial savings for residents of the state and only those prescription drugs that are not brand–name drugs and that have fewer than 4 competitor prescription drugs in the United States.

(f) The commissioner shall ensure that prescription drugs imported under the program under this section are not distributed, dispensed, or sold outside of the state.

(g) The prescription drug importation program under this section shall ensure all of the following:

1. Participation by any pharmacy or health care provider in the program is voluntary.

2. Any pharmacy or health care provider participating in the program has the appropriate license or other credential in this state.

3. Any pharmacy or health care provider participating in the program charges a consumer or health plan the actual acquisition cost of the imported prescription drug that is dispensed.

(h) The prescription drug importation program under this section shall ensure that a payment by a health plan or health insurance policy for a prescription drug imported under the program reimburses no more than the actual acquisition cost of the imported prescription drug that is dispensed.

(i) The prescription drug importation program under this section shall ensure that any health plan or health insurance policy participating in the program does all of the following:

1. Maintains a formulary and claims payment system with current information on prescription drugs imported under the program.

2. Bases cost–sharing amounts for participants or insureds under the plan or policy on no more than the actual acquisition cost of the prescription drug imported under the program that is dispensed to the participant or insured.

3. Demonstrates to the commissioner or a state agency designated by the commissioner how premiums under the policy or plan are affected by savings on prescription drugs imported under the program.

(j) Any wholesale distributor importing prescription drugs under the program under this section shall limit its profit margin to the amount established by the commissioner or a state agency designated by the commissioner.

(k) The prescription drug importation program under this section may not import any generic prescription drug that would violate federal patent laws on branded products in this country.

(L) The prescription drug importation program under this section shall comply to the extent practical and feasible, before the prescription drug to be imported comes into the possession of the state's wholesale distributor and fully after the prescription drug to be imported is in the possession of the state's wholesale distributor, with tracking and tracing requirements of 21 USC 360eee to 360eee–1.

(m) The prescription drug importation program under this section shall establish a fee or other mechanism to finance the program that does not jeopardize significant savings to residents of the state.

(n) The prescription drug importation program under this section shall have an audit function that ensures all of the following:

1. The commissioner has a sound methodology to determine the most cost–effective prescription drugs to include in the importation program under this section.

2. The commissioner has a process in place to select Canadian suppliers that are high quality, high performing, and in full compliance with Canadian laws.

3. Prescription drugs imported under the program are pure, unadulterated, potent, and safe.

4. The prescription drug importation program is complying with the requirements of this subsection.

5. The prescription drug importation program under this section is adequately financed to support administrative functions of the program while generating significant cost savings to residents of the state.

6. The prescription drug importation program under this section does not put residents of the state at a higher risk than if the program did not exist.

7. The prescription drug importation program under this section provides and is projected to continue to provide substantial cost savings to residents of the state.

(2) ANTICOMPETITIVE BEHAVIOR. The commissioner, in consultation with the attorney general, shall identify the potential for and monitor anticompetitive behavior in industries affected by a prescription drug importation program.

(3) APPROVAL OF PROGRAM DESIGN; CERTIFICATION. No later than the first day of the 7th month beginning after the effective date of this subsection .... [LRB inserts date], the commissioner shall submit to the joint committee on finance a report that includes the design of the prescription drug importation program in accordance with this section. The commissioner may not submit the proposed prescription drug importation program to the federal department of health and human services unless the joint committee on finance approves the proposed prescription drug implementation program. Within 14 days of the date of approval by the joint committee on finance of the proposed prescription drug importation program, the commissioner shall submit to the federal department of health and human services a request for certification of the approved prescription drug importation program.

(4) IMPLEMENTATION OF CERTIFIED PROGRAM. After the federal department of health and human services certifies the prescription drug importation program submitted under sub. (3), the commissioner shall begin implementation of the program, and the program shall be fully operational by 180 days after the date of certification by the federal department of health and human services. The commissioner shall do all of the following to implement the prescription drug

importation program to the extent the action is in accordance with other state laws and the certification by the federal department of health and human services:

(a) Become a licensed wholesale distributor, designate another state agency to become a licensed wholesale distributor, or contract with a licensed wholesale distributor.

(b) Contract with one or more Canadian suppliers that meet the criteria in sub. (1) (c) and (n).

(c) Create an outreach and marketing plan to communicate with and provide information to health plans and health insurance policies, employers, pharmacies, health care providers, and residents of the state on participating in the prescription drug importation program.

(d) Develop and implement a registration process for health plans and health insurance policies, pharmacies, and health care providers interested in participating in the prescription drug importation program.

(e) Create a publicly accessible source for listing prices of prescription drugs imported under the program.

(f) Create, publicize, and implement a method of communication to promptly answer questions from and address the needs of persons affected by the implementation of the program before the program is fully operational.

(g) Establish the audit functions under sub. (1) (n) with a timeline to complete each audit function every 2 years.

(h) Conduct any other activities determined by the commissioner to be important to successful implementation of the prescription drug importation program under this section.

(5) REPORT. By January 1 and July 1 of each year, the commissioner shall submit to the joint committee on finance a report including all of the following:

(a) A list of prescription drugs included in the importation program under this section.

(b) The number of pharmacies, health care providers, and health plans and health insurance policies participating in the prescription drug importation program under this section.

(c) The estimated amount of savings to residents of the state, health plans and health insurance policies, and employers resulting from the implementation of the prescription drug importation program under this section reported from the date of the previous report under this subsection and from the date the program was fully operational.

(d) Findings of any audit functions under sub. (1) (n) completed since the date of the previous report under this subsection.

(6) RULEMAKING. The commissioner may promulgate any rules necessary to implement this section.

SECTION 411k. 601.59 of the statutes is created to read:

601.59 State-based exchange. (1) DEFINITIONS. In this section:

(a) "Exchange" has the meaning given in 45 CFR 155.20.

(b) "State–based exchange on the federal platform" means an exchange that is described in and meets the requirements of 45 CFR 155.200 (f) and is approved by the federal secretary of health and human services under 45 CFR 155.106.

(c) "State–based exchange without the federal platform" means an exchange, other than one described in 45 CFR 155.200 (f), that performs all the functions

described in 45 CFR 155.200 (a) and is approved by the federal secretary of health and human services under 45 CFR 155.106.

(2) ESTABLISHMENT AND OPERATION OF STATE-BASED EXCHANGE. The commissioner shall establish and operate an exchange that at first is a state–based exchange on the federal platform and then subsequently transitions to a state–based exchange without the federal platform. The commissioner shall develop procedures to address the transition from the state–based exchange on the federal platform to the state–based exchange without the federal platform, including the circumstances that shall be met in order for the transition to occur.

(3) AGREEMENT WITH FEDERAL GOVERNMENT. The commissioner may enter into any agreement with the federal government necessary to facilitate the implementation of this section.

(4) USER FEES. The commissioner shall impose a user fee, as authorized under 45 CFR 155.160 (b) (1), on each insurer that offers a health plan through the state–based exchange on the federal platform or the state–based exchange without the federal platform. The user fee shall be applied at one of the following rates on the total monthly premiums charged by an insurer for each policy under the plan where enrollment is through the exchange:

(a) For any plan year for which the commissioner operates a state–based exchange on the federal platform, the rate is 0.5 percent.

(b) For the first 2 plan years for which the commissioner operates a state–based exchange without the federal platform, the rate is 3 percent.

(c) Beginning with the 3rd plan year for which the commissioner operates a state–based exchange without the federal platform, the rate shall be set by the commissioner by rule.

(5) RULES. The commissioner may promulgate rules necessary to implement this section.

SECTION 411n. Subchapter VI (title) of chapter 601 [precedes 601.78] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VI

PRESCRIPTION DRUG

AFFORDABILITY REVIEW BOARD

601.78 Definitions. In this subchapter:

(1) "Biologic" means a drug that is produced or distributed in accordance with a biologics license application approved under 21 CFR 601.20.

(2) "Biosimilar" means a drug that is produced or distributed in accordance with a biologics license application approved under 42 USC 262 (k) (3).

(3) "Board" means the prescription drug affordability review board established under s. 15.735 (1).

(4) "Brand name drug" means a drug that is produced or distributed in accordance with an original new drug application approved under 21 USC 355 (c), other than an authorized generic drug, as defined in 42 CFR 447.502.

(5) "Drug product" means a brand name drug, a generic drug, a biologic, a biosimilar, or an over–the–counter drug.

(6) "Financial benefit" includes an honoraria, fee, stock, the value of the stock holdings of a member of the board or any immediate family member, as defined in s. 97.605 (4) (a) 2., and any direct financial benefit deriving from the finding of a review conducted under s. 601.79.

(7) "Generic drug" means any of the following:

(a) A retail drug that is marketed or distributed in accordance with an abbreviated new drug application approved under 21 USC 355 (j).

(b) An authorized generic drug, as defined in 42 CFR 447.502.

(c) A drug that entered the market prior to 1962 and was not originally marketed under a new drug application.

(8) "Manufacturer" means an entity that does all of the following:

(a) Engages in the manufacture of a drug product or enters into a lease with another manufacturer to market and distribute a prescription drug product under the entity's own name.

(b) Sets or changes the wholesale acquisition cost of the drug product or prescription drug product described in par. (a).

(9) "Over–the–counter drug" means a drug intended for human use that does not require a prescription and meets the requirements of 21CFR parts 328 to 364.

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

(11) "Prescription drug product" means a brand name drug, a generic drug, a biologic, or a biosimilar.

601.785 Prescription drug affordability review board. (1) MISSION. The purpose of the board is to protect state residents, the state, local governments, health plans, health care providers, pharmacies licensed in this state, and other stakeholders of the health care system in this state from the high costs of prescription drug products.

(2) POWERS AND DUTIES. (a) The board shall do all of the following:

1. Meet in open session at least 4 times per year to review prescription drug product pricing information, except that the chair may cancel or postpone a meeting if there is no business to transact.

2. To the extent practicable, access and assess pricing information for prescription drug products by doing all of the following:

a. Accessing and assessing information from other states by entering into memoranda of understanding with other states to which manufacturers report pricing information.

b. Assessing spending for specific prescription drug products in this state.

c. Accessing other available pricing information.

(b) The board may:

1. Promulgate rules for the administration of this subchapter.

2. Enter into a contract with an independent 3rd party for any service necessary to carry out the powers and duties of the board. Unless written permission is granted by the board, any person with whom the board contracts may not release, publish, or otherwise use any information to which the person has access under the contract.

(3) MEETING REQUIREMENTS. (a) Pursuant to s. 19.84, the board shall provide public notice of each board meeting at least 2 weeks prior to the meeting and shall make the materials for each meeting publicly available at least one week prior to the meeting.

(b) Notwithstanding s. 19.84 (2), the board shall provide an opportunity for public comment at each open meeting and shall provide the public with the opportunity to provide written comments on pending decisions of the board.

(c) Notwithstanding subch. V of ch. 19, any portion of a meeting of the board concerning proprietary data and information shall be conducted in closed session and shall in all respects remain confidential.

(d) The board may allow expert testimony at any meeting, including when the board meets in closed session.

(4) CONFLICTS OF INTEREST. (a) A member of the board shall recuse himself or herself from a decision by the board relating to a prescription drug product if the member or an immediate family member, as defined in s. 97.605 (4) (a) 2., has received or could receive any of the following:

1. A direct financial benefit deriving from a determination, or a finding of a study or review, by the board relating to the prescription drug product.

2. A financial benefit in excess of $5,000 in a calendar year from any person who owns, manufactures, or provides a prescription drug product to be studied or reviewed by the board.

(b) A conflict of interest shall be disclosed by the board when hiring board staff, by the appointing authority when appointing members to the board, and by the board when a member of the board is recused from any final decision resulting from a review of a prescription drug product.

(c) A conflict of interest shall be disclosed no later than 5 days after the conflict is identified, except that, if the conflict is identified within 5 days of an open meeting of the board, the conflict shall be disclosed prior to the meeting.

(d) The board shall disclose a conflict of interest under this subsection on the board's Internet site unless the chair of the board recuses the member from a final decision resulting from a review of the prescription drug product. The disclosure shall include the type, nature, and magnitude of the interests of the member involved.

(e) A member of the board or a 3rd–party contractor may not accept any gift or donation of services or property that indicates a potential conflict of interest or has the appearance of biasing the work of the board.

601.79 Drug cost affordability review. (1) IDENTIFICATION OF DRUGS. The board shall identify prescription drug products that are any of the following:

(a) A brand name drug or biologic that, as adjusted annually to reflect adjustments to the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, has a launch wholesale acquisition cost of at least $30,000 per year or course of treatment or whose wholesale acquisition cost increased at least $3,000 during a 12–month period.

(b) A biosimilar drug that has a launch wholesale acquisition cost that is not at least 15 percent lower than the referenced brand biologic at the time the biosimilar is launched.

(c) A generic drug that has a wholesale acquisition cost, as adjusted annually to reflect adjustments to the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, that meets all of the following conditions:

1. Is at least $100 for a supply lasting a patient for a period of 30 consecutive days based on the recommended dosage approved for labeling by the U.S. food and drug administration, a supply lasting a patient for fewer than 30 days based on the recommended dosage approved for labeling by the federal food and drug administration, or one unit of the drug if the labeling approved by the federal food and drug administration does not recommend a finite dosage.

2. Increased by at least 200 percent during the preceding 12–month period, as determined by the difference between the resulting wholesale acquisition cost and the average of the wholesale acquisition cost reported over the preceding 12 months.

(d) Other prescription drug products, including drugs to address public health emergencies, that may create affordability challenges for the health care system and patients in this state.

(2) AFFORDABILITY REVIEW. (a) After identifying prescription drug products under sub. (1), the board shall determine whether to conduct an affordability review for each identified prescription drug product by seeking stakeholder input about the prescription drug product and considering the average patient cost share of the prescription drug product.

(b) The information to conduct an affordability review under par. (a) may include any document and research related to the manufacturer's selection of the introductory price or price increase of the prescription drug product, including life cycle management, net average price in this state, market competition and context, projected revenue, and the estimated value or cost–effectiveness of the prescription drug product.

(c) The failure of a manufacturer to provide the board with information for an affordability review does not affect the authority of the board to conduct the review.

(3) AFFORDABILITY CHALLENGE. When conducting an affordability review of a prescription drug product, the board shall determine whether use of the prescription drug product that is fully consistent with the labeling approved by the federal food and drug administration or standard medical practice has led or will lead to an affordability challenge for the health care system in this state, including high out–of–pocket costs for patients. To the extent practicable, in determining whether

a prescription drug product has led or will lead to an affordability challenge, the board shall consider all of the following factors:

(a) The wholesale acquisition cost for the prescription drug product sold in this state.

(b) The average monetary price concession, discount, or rebate the manufacturer provides, or is expected to provide, to health plans in this state as reported by manufacturers and health plans, expressed as a percent of the wholesale acquisition cost for the prescription drug product under review.

(c) The total amount of the price concessions, discounts, and rebates the manufacturer provides to each pharmacy benefit manager for the prescription drug product under review, as reported by the manufacturer and pharmacy benefit manager and expressed as a percent of the wholesale acquisition costs.

(d) The price at which therapeutic alternatives have been sold in this state.

(e) The average monetary concession, discount, or rebate the manufacturer provides or is expected to provide to health plan payors and pharmacy benefit managers in this state for therapeutic alternatives.

(f) The costs to health plans based on patient access consistent with labeled indications by the federal food and drug administration and recognized standard medical practice.

(g) The impact on patient access resulting from the cost of the prescription drug product relative to insurance benefit design.

(h) The current or expected dollar value of drug–specific patient access programs that are supported by the manufacturer.

(i) The relative financial impacts to health, medical, or social services costs that can be quantified and compared to baseline effects of existing therapeutic alternatives.

(j) The average patient copay or other cost sharing for the prescription drug product in the state.

(k) Any information a manufacturer chooses to provide.

(L) Any other factors as determined by the board by rule.

(4) UPPER PAYMENT LIMIT. (a) If the board determines under sub. (3) that use of a prescription drug product has led or will lead to an affordability challenge, the board shall establish an upper payment limit for the prescription drug product after considering all of the following:

1. The cost of administering the drug.

2. The cost of delivering the drug to consumers.

3. Other relevant administrative costs related to the drug.

(b) For a prescription drug product identified in sub. (1) (d), the board shall solicit information from the manufacturer regarding the price increase. To the extent that the price increase is not a result of the need for increased manufacturing capacity or other effort to improve patient access during a public health emergency, the board shall establish an upper payment limit under par. (a) that is equal to the cost to consumers prior to the price increase.

(c) 1. The upper payment limit established under this subsection shall apply to all purchases and payor reimbursements of the prescription drug product dispensed or administered to individuals in this state in person, by mail, or by other means.

2. Notwithstanding subd. 1., while state–sponsored and state–regulated health plans and health programs shall limit drug reimbursements and drug payment to no more than the upper payment limit established under this subsection, a plan subject to the Employee Retirement Income Security Act of 1974 or Part D of Medicare under 42 USC 1395w–101 et seq. may choose to reimburse more than the upper payment limit. A provider who dispenses and administers a prescription drug product in this state to an individual in this state may not bill a payor more than the upper payment limit to the patient regardless of whether a plan subject to the Employee Retirement Income Security Act of 1974 or Part D of Medicare under 42 USC 1395w–101 et seq. chooses to reimburse the provider above the upper payment limit.

(5) PUBLIC INSPECTION. Information submitted to the board under this section shall be open to public inspection only as provided under ss. 19.31 to 19.39.

(6) NO PROHIBITION ON MARKETING. Nothing in this section may be construed to prevent a manufacturer from marketing a prescription drug product approved by the federal food and drug administration while the prescription drug product is under review by the board.

(7) APPEALS. A person aggrieved by a decision of the board may request an appeal of the decision no later than 30 days after the board makes the determination. The board shall hear the appeal and make a final decision no later than 60 days after the appeal is requested. A person aggrieved by a final decision of the board may petition for judicial review in a court of competent jurisdiction.".

100. Page 355, line 3: after that line insert:

"**SECTION 412b.** 609.045 of the statutes is created to read:

609.045 Balance billing; emergency medical services. (1) DEFINITIONS. In this section:

(a) "Emergency medical services" means emergency medical services for which coverage is required under s. 632.85 (2) and includes emergency medical services described under s. 632.85 (2) as if section 1867 of the federal Social Security Act applied to an independent freestanding emergency department.

(b) "Preferred provider plan," notwithstanding s. 609.01 (4), includes only any preferred provider plan, as defined under 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.

(c) "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.

(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 based on whether or not the health care provider providing the services is a participating provider or participating emergency 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 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 service is no greater than the requirements that would apply if the emergency medical service were provided by a participating provider or in a participating facility.

3. Any cost–sharing amount imposed on an enrollee for the emergency medical service is calculated as if the total amount that would have been charged for the emergency medical service if provided by a participating provider or in a participating facility is equal to the amount paid to the provider or facility that is not a participating provider or facility as determined by the commissioner.

4. The plan does all of the following:

a. No later than 30 days after the provider or 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 provider or facility a total amount that, incorporating any initial payment under subd. 4. a., is equal to the amount by which the rate for a provider or facility that is not a participating provider or facility 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 an emergency medical service provided by a participating provider or in a participating facility.

(3) PROVIDER BILLING LIMITATION FOR EMERGENCY MEDICAL SERVICES; AMBULANCE SERVICES. A provider of emergency medical services or a facility in which emergency medical services are provided that is entitled to payment under sub. (2) may not bill or hold liable an enrollee for any amount for the emergency medical service that is more than the cost–sharing amount determined under sub. (2) (c) 3. for the emergency service. A provider of ambulance services that is not a participating provider under an enrollee's defined network plan, preferred provider plan, or self–insured governmental plan may not bill or hold liable an enrollee for any amount of the ambulance service that is more than the cost–sharing amount that the enrollee would be charged if the provider of ambulance services was a participating provider under the enrollee's plan.

(4) 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 amount paid to the provider that is not a participating provider as determined by the commissioner.

(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 that 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.

(5) CHARGING FOR SERVICES BY NONPARTICIPATING PROVIDER; NOTICE AND CONSENT. (a) Except as provided in par. (c), a provider of an item or service that is entitled to payment under sub. (4) may not bill or hold liable an enrollee for any amount for the item or service that is more than the cost–sharing amount determined under sub. (4) (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 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 facility that 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 enrollee provides consent to the 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.

6. A signed copy of the consent described under subd. 5. 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 that is entitled to payment under sub. (4) may not bill or hold liable an enrollee for any amount for the ancillary item or service that is more than the cost–sharing amount determined under sub. (4) (b) for the item or service, unless the commissioner specifies by rule that the provider may balance bill for the specified item or service, if the ancillary item or service is any of the following:

1. Related to an emergency medical service.

2. Anesthesiology.

3. Pathology.

4. Radiology.

5. Neonatology.

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

7. 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.

(6) NOTICE BY PROVIDER OR FACILITY. Beginning no later than January 1, 2022, a health care provider or health care facility shall make available, including posting on an Internet site, to enrollees in defined network plans, preferred provider plans, and self–insured governmental plans notice of the requirements on a provider or facility under subs. (3) and (5), 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.

(7) 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 (4) (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 the 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.

(8) 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 of time.

(b) If an enrollee is a continuing care patient and is obtaining items or services from a participating provider or facility and the contract between the defined network plan, preferred provider plan, or self–insured governmental plan and the participating provider or facility is terminated or the coverage of benefits that include the items or services provided by the participating provider or facility are terminated by 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 provider or 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.

(9) RULE MAKING. The commissioner may promulgate any rules necessary to implement this section, including specifying the independent dispute resolution process. The commissioner may promulgate rules to modify the list of those items and services for which a provider may not balance bill under sub. (5) (c).

SECTION 412c. 609.713 of the statutes is created to read:

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

SECTION 412d. 609.719 of the statutes is created to read:

609.719 Telehealth services. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.871.

SECTION 412e. 609.83 of the statutes, as affected by 2021 Wisconsin Act 9, is amended to read:

609.83 Coverage of drugs and devices; application of payments. Limited service health organizations, preferred provider plans, and defined network plans are subject to ss. 632.853, 632.861, 632.862, and 632.895 (16t) and (16v).

SECTION 412f. 609.83 of the statutes, as affected by 2021 Wisconsin Act .... (this act), section 412e, is amended to read:

609.83 Coverage of drugs and devices; application of payments. Limited service health organizations, preferred provider plans, and defined network plans are subject to ss. 632.853, 632.861, 632.862, and 632.895 (6) (b), (16t), and (16v).

SECTION 412g. 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 412h. 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 412i. 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 412j. 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 412k. 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 412L. 628.34 (3) (a) of the statutes is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ss. 632.365, 632.729, 632.746 ~~and~~, 632.748, and 632.7496. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

SECTION 412m. 628.34 (3) (a) of the statutes, as affected by 2021 Wisconsin Act .... (this act), section 412L, is amended to read:

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

expenses involved, subject to ss. 632.365, 632.728, 632.729, 632.746, 632.748, and 632.7496. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

SECTION 412n. 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 sexual orientation, gender identity, or whether or not any employee or individual has a preexisting condition. A health benefit plan may restrict enrollment in coverage described in this paragraph to open or special enrollment periods.

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

(3) PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS. (a) An individual health benefit plan or a self–insured health plan may not establish rules for the eligibility of any individual to enroll, or for the continued eligibility of any individual

to remain enrolled, under the plan based on any of the following health status–related factors in relation to the individual or a dependent of the individual:

1. Health status.

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

3. Claims experience.

4. Receipt of health care.

5. Medical history.

6. Genetic information.

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

8. Disability.

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

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

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

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

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

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

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

(5) 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 412p. 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 412q. 632.746 (1) (b) of the statutes is repealed.

SECTION 412r. 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 412s. 632.746 (2) (c), (d) and (e) of the statutes are repealed.

SECTION 412t. 632.746 (3) (a) of the statutes is repealed.

SECTION 412u. 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

SECTION 412v. 632.746 (3) (d) 2. and 3. of the statutes are repealed.

SECTION 412w. 632.746 (5) of the statutes is repealed.

SECTION 412x. 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 412y. 632.748 (2) of the statutes is amended to read:

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

SECTION 412yc. 632.7495 (4) (b) of the statutes is amended to read:

632.7495 **(4)** (b) The coverage has a term of not more than ~~12~~ 3 months.

SECTION 412ye. 632.7495 (4) (c) of the statutes is amended 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~~ 6 months. For purposes of this paragraph, coverage periods are consecutive if there are no more than 63 days between the coverage periods.

SECTION 412yg. 632.7496 of the statutes is created to read:

632.7496 Coverage requirements for short-term plans. (1) DEFINITION. In this section, "short-term, limited duration plan" means an individual health benefit plan described in s. 632.7495 (4) that an insurer is not required to renew.

(2) GUARANTEED ISSUE. Every short-term, limited duration plan shall accept every individual in this state who applies for coverage whether or not any individual has a preexisting condition.

(3) PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS. (a) A short-term, limited duration 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) A short-term, limited duration plan may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay, on the basis of any health status-related factor under par. (a) with respect to the individual or a dependent of the individual, a premium or contribution or a deductible, copayment, or coinsurance amount that is greater than the premium or contribution or

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

(4) PREMIUM RATE VARIATION. A short–term, limited duration plan may vary premium rates for a specific plan based only on the following considerations:

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

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

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

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

(5) ANNUAL AND LIFETIME LIMITS. A short–term, limited duration 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) Limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the plan for the initial or cumulative duration of the plan.

SECTION 412yj. 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

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

policy, as defined in s. 632.895 (1) (a), or a self–insured health plan, as defined in s. 632.85 (1) (c).

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

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

SECTION 412ym. 632.76 (2) (ac) 3. (intro.) of the statutes is amended to read:

632.76 **(2)** (ac) 3. (intro.) 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, limited duration policy subject to s. 632.7495 (4) and (5):

SECTION 412yp. 632.76 (2) (ac) 3. b. of the statutes is amended to read:

632.76 **(2)** (ac) 3. b. The policy ~~shall reduce the length of time during which a~~ may not impose any 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~~.

SECTION 412ys. 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 412yu. 632.796 of the statutes is created to read:

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

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

SECTION 412yw. 632.862 of the statutes is created to read:

632.862 Application of prescription drug payments. (1) DEFINITIONS. In this section:

(a) "Brand name" has the meaning given in s. 450.12 (1) (a).

(b) "Brand name drug" means any of the following:

1. A prescription drug that contains a brand name and that has no generic equivalent.

2. A prescription drug that contains a brand name and has a generic equivalent but for which the enrollee has received prior authorization from the insurer offering the disability insurance policy or the self–insured health plan or authorization from a physician to obtain the prescription drug under the policy or plan.

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

(d) "Prescription drug" has the meaning given in s. 450.01 (20)

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

(2) APPLICATION OF DISCOUNTS. A disability insurance policy that offers a prescription drug benefit or a self–insured health plan shall apply to any calculation of an out–of–pocket maximum and to any deductible of the policy or plan for an enrollee the amount that any discount provided by the manufacturer of a brand name drug reduces the cost sharing amount charged to an enrollee for that brand name drug.

SECTION 412yz. 632.8655 of the statutes is created to read:

632.8655 Prescription drug cost reporting. (1) DEFINITIONS. In this section:

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

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

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

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

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

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

(3) PUBLIC REPORTING. The commissioner shall publicly post covered hospital documentation of how each hospital spends the margin revenue. The commissioner shall analyze data collected under this section and publish annually a report including an analysis on hospital–specific margins and how that revenue is spent or allocated on a hospital–specific basis. The commissioner shall keep any trade secret or proprietary information confidential.

SECTION 412z. 632.8665 of the statutes is created to read:

632.8665 Prescription drug cost reporting. (1) DEFINITIONS. In this section:

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

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

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

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

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

(f) "Pharmacy services administrative organization" means an entity that provides contracting and other administrative services to a pharmacy to assist the pharmacy in interactions with a 3rd–party payer, pharmacy benefit manager, wholesale drug distributor, or other entity.

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

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

(b) A manufacturer shall notify the commissioner if it is increasing the wholesale acquisition cost of a generic drug by more than 25 percent or by more than

$300 during any 12–month period or if it intends to introduce to market a generic drug that has an annual wholesale acquisition cost of $3,000 or more.

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

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

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

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

(a) The terms of the programs.

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

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

(6) PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS. By March 1 annually, each pharmacy services administrative organization shall report to the commissioner all of the following information:

(a) The negotiated reimbursement rate of the 25 prescription drugs with the highest reimbursement rates during the previous year.

(b) The 25 prescription drugs with the highest year–to–year change in reimbursement rate for the previous year.

(c) The schedule of fees charged by the organization to pharmacies.

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

(8) HEARING AND PUBLIC REPORTING. (a) The commissioner shall publicly post manufacturer price justification documents. The commissioner shall keep any trade secret or proprietary information confidential.

(b) The commissioner shall analyze data collected under this section and publish annually a report on emerging trends in prescription prices and price increases and shall annually conduct a public hearing based on the analysis under this paragraph. The report under this paragraph shall include analysis of manufacturer prices and price increases and analysis of how pharmacy benefit manager discounts and net costs compare to retail prices paid by patients.

SECTION 412zc. 632.868 of the statutes is created to read:

632.868 Insulin safety net programs. (1) DEFINITIONS. In this section:

(a) "Manufacturer" means a person engaged in the manufacturing of insulin that is self–administered on an outpatient basis.

(b) "Navigator" has the meaning given in s. 628.90 (3).

(c) "Patient assistance program" means a program established by a manufacturer under sub. (3) (a).

(d) "Pharmacy" means an entity licensed under s. 450.06 or 450.065.

(e) "Urgent need of insulin" means having less than a 7–day supply of insulin readily available for use and needing insulin in order to avoid the likelihood of suffering a significant health consequence.

(f) "Urgent need safety net program" means a program established by a manufacturer under sub. (2) (a).

(2) URGENT NEED SAFETY NET PROGRAM. (a) *Establishment of program*. No later than July 1, 2022, each manufacturer shall establish an urgent need safety net program to make insulin available in accordance with this subsection to individuals who meet the eligibility requirements under par. (b).

(b) *Eligible individual*. An individual shall be eligible to receive insulin under an urgent need safety net program if all of the following conditions are met:

1. The individual is in urgent need of insulin.

2. The individual is a resident of this state.

3. The individual is not receiving public assistance under ch. 49.

4. The individual is not enrolled in prescription drug coverage through an individual or group health plan that limits the total cost sharing amount, including copayments, deductibles, and coinsurance, that an enrollee is required to pay for a 30–day supply of insulin to no more than $75, regardless of the type or amount of insulin prescribed.

5. The individual has not received insulin under an urgent need safety net program within the previous 12 months, except as allowed under par. (d).

(c) *Provision of insulin under an urgent need safety net program*. 1. In order to receive insulin under an urgent need safety net program, an individual who meets the eligibility requirements under par. (b) shall provide a pharmacy with all of the following:

a. A completed application, on a form prescribed by the commissioner that shall include an attestation by the individual, or the individual's parent or legal guardian if the individual is under the age of 18, that the individual meets all of the eligibility requirements under par. (b).

b. A valid insulin prescription.

c. A valid Wisconsin driver's license or state identification card. If the individual is under the age of 18, the individual's parent or legal guardian shall meet this requirement.

2. Upon receipt of the information described in subd. 1. a. to c., the pharmacist shall dispense a 30–day supply of the prescribed insulin to the individual. The pharmacy shall also provide the individual with the information sheet described in sub. (8) (b) 2. and the list of navigators described in sub. (8) (c). The pharmacy may collect a copayment, not to exceed $35, from the individual to cover the pharmacy's costs of processing and dispensing the insulin. The pharmacy shall notify the health care practitioner who issued the prescription no later than 72 hours after the insulin is dispensed.

3. A pharmacy that dispenses insulin under subd. 2. may submit to the manufacturer, or the manufacturer's vendor, a claim for payment that is in accordance with the national council for prescription drug programs' standards for

electronic claims processing, except that no claim may be submitted if the manufacturer agrees to send the pharmacy a replacement of the same insulin in the amount dispensed. If the pharmacy submits an electronic claim, the manufacturer or vendor shall reimburse the pharmacy in an amount that covers the pharmacy's acquisition cost.

4. A pharmacy that dispenses insulin under subd. 2. shall retain a copy of the application form described in subd. 1. a.

(d) *Eligibility of certain individuals*. An individual who has applied for public assistance under ch. 49 but for whom a determination of eligibility has not been made or whose coverage has not become effective or an individual who has an appeal pending under sub. (3) c. 4. may access insulin under this subsection if the individual is in urgent need of insulin. To access a 30–day supply of insulin, the individual shall attest to the pharmacy that the individual is described in this paragraph and comply with par. (c) 1.

(3) PATIENT ASSISTANCE PROGRAM. (a) *Establishment of program*. No later than July 1, 2022, each manufacturer shall establish a patient assistance program to make insulin available in accordance with this subsection to individuals who meet the eligibility requirements under par. (b). Under the program, the manufacturer shall do all of the following:

1. Provide the commissioner with information regarding the program, including contact information for individuals to call for assistance in accessing the program.

2. Provide a hotline for individuals to call or access between 8 a.m. and 10 p.m. on weekdays and between 10 a.m. and 6 p.m. on Saturdays.

3. List the eligibility requirements under par. (b) on the manufacturer's Internet site.

4. Maintain the privacy of all information received from an individual applying for or participating in the program and not sell, share, or disseminate the information unless required under this section or authorized, in writing, by the individual.

(b) *Eligible individual*. An individual shall be eligible to receive insulin under a patient assistance program if all of the following conditions are met:

1. The individual is a resident of this state.

2. The individual, or the individual's parent or legal guardian if the individual is under the age of 18, has a valid Wisconsin driver's license or state identification card.

3. The individual has a valid insulin prescription.

4. The family income of the individual does not exceed 400 percent of the poverty line as defined and revised annually under 42 USC 9902 (2) for a family the size of the individual's family,

5. The individual is not receiving public assistance under ch. 49.

6. The individual is not eligible to receive health care through a federally funded program or receive prescription drug benefits through the U.S. department of veterans affairs, except that this subdivision does not apply to an individual who is enrolled in a policy under Part D of Medicare under 42 USC 1395w–101 et seq. if the individual has spent at least $1,000 on prescription drugs in the current calendar year.

7. The individual is not enrolled in prescription drug coverage through an individual or group health plan that limits the total cost sharing amount, including

copayments, deductibles, and coinsurance, that an enrollee is required to pay for a 30–day supply of insulin to no more than $75, regardless of the type or amount of insulin needed.

(c) *Application for patient assistance program*. 1. An individual may apply to participate in a patient assistance program by filing an application with the manufacturer who established the program, the individual's health care practitioner if the practitioner participates in the program, or a navigator included on the list under sub. (8) (c). A health care practitioner or navigator shall immediately submit the application to the manufacturer. Upon receipt of an application, the manufacturer shall determine the individual's eligibility under par. (b) and, except as provided in subd. 2., notify the individual of the determination no later than 10 days after receipt of the application.

2. If necessary to determine the individual's eligibility under par. (b), the manufacturer may request additional information from an individual who has filed an application under subd. 1. no later than 5 days after receipt of the application. Upon receipt of the additional information, the manufacturer shall determine the individual's eligibility under par. (b) and notify the individual of the determination no later than 3 days after receipt of the requested information.

3. Except as provided in subd. 5., if the manufacturer determines under subd. 1. or 2. that the individual is eligible for the patient assistance program, the manufacturer shall provide the individual with a statement of eligibility. The statement of eligibility shall be valid for 12 months and may be renewed upon a determination by the manufacturer that the individual continues to meet the eligibility requirements of par. (b).

4. If the manufacturer determines under subd. 1. or 2. that the individual is not eligible for the patient assistance program, the manufacturer shall provide the reason for the determination in the notification under subd. 1. or 2. The individual may appeal the determination by filing an appeal with the commissioner that shall include all of the information provided to the manufacturer under subds. 1. and 2. The commissioner shall establish procedures for deciding appeals under this subdivision. The commissioner shall issue a decision no later than 10 days after the appeal is filed, and the commissioner's decision shall be final. If the commissioner determines that the individual meets the eligibility requirements under par. (b), the manufacturer shall provide the individual with the statement of eligibility described in subd. 3.

5. In the case of an individual who has prescription drug coverage through an individual or group health plan, if the manufacturer determines under subd. 1. or 2. that the individual is eligible for the patient assistance program but also determines that the individual's insulin needs are better addressed through the use of the manufacturer's copayment assistance program rather than the patient assistance program, the manufacturer shall inform the individual of the determination and provide the individual with the necessary coupons to submit to a pharmacy. The individual may not be required to pay more than the copayment amount specified in par. (d) 2.

(d) *Provision of insulin under a patient assistance program*. 1. Upon receipt from an individual of the eligibility statement described in par. (c) 3. and a valid insulin prescription, a pharmacy shall submit an order containing the name of the insulin and daily dosage amount to the manufacturer. The pharmacy shall include with the order the pharmacy's name, shipping address, office telephone number, fax

number, electronic mail address, and contact name, as well as any days or times when deliveries are not accepted by the pharmacy.

2. Upon receipt of an order meeting the requirements under subd. 1., the manufacturer shall send the pharmacy a 90–day supply of insulin, or lesser amount if requested in the order, at no charge to the individual or pharmacy. The pharmacy shall dispense the insulin to the individual associated with the order. The insulin shall be dispensed at no charge to the individual, except that the pharmacy may collect a copayment from the individual to cover the pharmacy's costs for processing and dispensing in an amount not to exceed $50 for each 90–day supply of insulin. The pharmacy may not seek reimbursement from the manufacturer or a 3rd–party payer.

3. The pharmacy may submit a reorder to the manufacturer if the individual's eligibility statement described in par. (c) 3. has not expired. The reorder shall be treated as an order for purposes of subd. 2.

4. Notwithstanding subds. 2. and 3., a manufacturer may send the insulin directly to the individual if the manufacturer provides a mail–order service option, in which case the pharmacy may not collect a copayment from the individual.

(4) EXCEPTIONS. (a) This section does not apply to a manufacturer who shows to the commissioner's satisfaction that the manufacturer's annual gross revenue from insulin sales in this state does not exceed $2,000,000.

(b) A manufacturer may not be required to make an insulin product available under sub. (2) or (3) if the wholesale acquisition cost of the insulin product does not exceed $8, as adjusted annually based on the U.S. consumer price index for all urban consumers, U.S. city average, per milliliter or the applicable national council for prescription drug programs' plan billing unit.

(5) CONFIDENTIALITY. All medical information solicited or obtained by any person under this section shall be subject to the applicable provisions of state law relating to confidentiality of medical information, including s. 610.70.

(6) REIMBURSEMENT PROHIBITION. No person, including a manufacturer, pharmacy, pharmacist, or 3rd–party administrator, as part of participating in an urgent need safety net program or patient assistance program may request or seek, or cause another person to request or seek, any reimbursement or other compensation for which payment may be made in whole or in part under a federal health care program, as defined in 42 USC 1320a–7b (f).

(7) REPORTS. (a) Annually, no later than March 1, each manufacturer shall report to the commissioner all of the following information for the previous calendar year:

1. The number of individuals who received insulin under the manufacturer's urgent need safety net program.

2. The number of individuals who sought assistance under the manufacturer's patient assistance program and the number of individuals who were determined to be ineligible under sub. (3) (c) 4.

3. The wholesale acquisition cost of the insulin provided by the manufacturer through the urgent need safety net program and patient assistance program.

(b) Annually, no later than April 1, the commissioner shall submit to the governor and the chief clerk of each house of the legislature, for distribution to the legislature under s. 13.172 (2), a report on the urgent need safety net programs and patient assistance programs that includes all of the following:

1. The information provided to the commissioner under par. (a).

2. The penalties assessed under sub. (9) during the previous calendar year, including the name of the manufacturer and amount of the penalty.

(8) ADDITIONAL RESPONSIBILITIES OF COMMISSIONER. (a) *Application form*. The commissioner shall make the application form described in sub. (2) (c) 1. a. available on the office's Internet site and shall make the form available to pharmacies and health care providers who prescribe or dispense insulin, hospital emergency departments, urgent care clinics, and community health clinics.

(b) *Public outreach*. 1. The commissioner shall conduct public outreach to create awareness of the urgent need safety net programs and patient assistance programs.

2. The commissioner shall develop and make available on the office's Internet site an information sheet that contains all of the following information:

a. A description of how to access insulin through an urgent need safety net program.

b. A description of how to access insulin through a patient assistance program.

c. Information on how to contact a navigator for assistance in accessing insulin through an urgent need safety net program or patient assistance program.

d. Information on how to contact the commissioner if a manufacturer determines that an individual is not eligible for a patient assistance program.

e. A notification that an individual may contact the commissioner for more information or assistance in accessing ongoing affordable insulin options.

(c) *Navigators*. The commissioner shall develop a training program to provide navigators with information and the resources necessary to assist individuals in accessing appropriate long-term insulin options. The commissioner shall compile a list of navigators who have completed the training program and are available to

assist individuals in accessing affordable insulin coverage options. The list shall be made available on the office's Internet site and to pharmacies and health care practitioners who dispense and prescribe insulin.

(d) *Satisfaction surveys*. 1. The commissioner shall develop and conduct a satisfaction survey of individuals who have accessed insulin through urgent need safety net programs and patient assistance programs. The survey shall ask whether the individual is still in need of a long–term solution for affordable insulin and shall include questions about the individual's satisfaction with all of the following, if applicable:

a. Accessibility to urgent–need insulin.

b. Adequacy of the information sheet and list of navigators received from the pharmacy.

c. Helpfulness of a navigator.

d. Ease of access in applying for a patient assistance program and receiving insulin from the pharmacy under the program.

2. The commissioner shall develop and conduct a satisfaction survey of pharmacies that have dispensed insulin through urgent need safety net programs and patient assistance programs. The survey shall include questions about the pharmacy's satisfaction with all of the following, if applicable:

a. Timeliness of reimbursement from manufacturers for insulin dispensed by the pharmacy under urgent need safety net programs.

b. Ease in submitting insulin orders to manufacturers.

c. Timeliness of receiving insulin orders from manufacturers.

3. The commissioner may contract with a nonprofit entity to develop and conduct the surveys under subds. 1. and 2. and to evaluate the survey results.

4. No later than July 1, 2024, the commissioner shall submit to the governor and the chief clerk of each house of the legislature, for distribution to the legislature under s. 13.172 (2), a report on the results of the surveys under subds. 1. and 2.

(9) PENALTY. A manufacturer that fails to comply with this section may be assessed a penalty of up to $200,000 per month of noncompliance, with the maximum penalty increasing to $400,000 per month if the manufacturer continues to be in noncompliance after 6 months and increasing to $600,000 per month if the manufacturer continues to be in noncompliance after one year.

SECTION 412ze. 632.869 of the statutes is created to read:

632.869 Reimbursement to federal drug pricing program participants.

(**1**) In this section:

(a) "Covered entity" means an entity described in 42 USC 256b (a) (4) (A), (D), (E), (J), or (N) that participates in the federal drug pricing program under 42 USC 256b, a pharmacy of the entity, or a pharmacy contracted with the entity to dispense drugs purchased through the federal drug pricing program under 42 USC 256b.

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

(2) Any person, including a pharmacy benefit manager and 3rd–party payer, may not do any of the following:

(a) Reimburse a covered entity for a drug that is subject to an agreement under 42 USC 256b at a rate lower than that paid for the same drug to pharmacies that are not covered entities and are similar in prescription volume to the covered entity.

(b) Assess a covered entity any fee, charge back, or other adjustment on the basis of the covered entity's participation in the federal drug pricing program under 42 USC 256b.

SECTION 412zg. 632.871 of the statutes is created to read:

632.871 Telehealth services. (1) DEFINITIONS. In this section:

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

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

(c) "Telehealth" means a practice of health care delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communications that are used either during a patient visit or a consultation or are used to transfer medically relevant data about a patient. "Telehealth" does not include communications delivered solely by audio–only telephone, facsimile machine, or e–mail unless specified otherwise by rule.

(2) COVERAGE DENIAL PROHIBITED. No disability insurance policy or self–insured health plan may deny coverage for a treatment or service provided through telehealth on the basis that the treatment or service is provided through telehealth if that treatment or service is covered by the policy or plan when provided in person. A disability insurance policy or self–insured health plan may limit coverage of treatments or services provided through telehealth to those treatments or services that are medically necessary.

(3) CERTAIN LIMITATIONS ON TELEHEALTH PROHIBITED. A disability insurance policy or self–insured health plan may not subject a treatment or service provided through telehealth for which coverage is required under sub. (2) to any of the following:

(a) Any greater deductible, copayment, or coinsurance amount than would be applicable if the treatment or service is provided in person.

(b) Any policy or calendar year or lifetime benefit limit or other maximum limitation that is not imposed on other treatments or services covered by the plan that are not provided through telehealth.

(c) Prior authorization requirements that are not required for the same treatment or service when provided in person.

(d) Unique location requirements.

(4) DISCLOSURE OF COVERAGE OF CERTAIN TELEHEALTH SERVICES. A disability insurance policy or self–insured health plan that covers a telehealth treatment or service that has no equivalent in–person treatment or service, such as remote patient monitoring, shall specify in policy or plan materials the coverage of that telehealth treatment or service.

SECTION 412zh. 632.895 (6) (title) of the statutes is amended to read:

632.895 **(6)** (title) EQUIPMENT AND SUPPLIES FOR TREATMENT OF DIABETES; INSULIN.

SECTION 412zj. 632.895 (6) of the statutes is renumbered 632.895 (6) (a) and amended to read:

632.895 **(6)** (a) Every disability insurance policy ~~which~~ that provides coverage of expenses incurred for treatment of diabetes shall provide coverage for expenses incurred by the installation and use of an insulin infusion pump, coverage for all other equipment and supplies, including insulin or any other prescription medication, used in the treatment of diabetes, and coverage of diabetic self–management education programs. ~~Coverage~~ Except as provided in par. (b), coverage required under this subsection shall be subject to the same exclusions, limitations, deductibles, and coinsurance provisions of the policy as other covered expenses, except that insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

SECTION 412zk. 632.895 (6) (b) of the statutes is created to read:

632.895 **(6)** (b) 1. In this paragraph:

a. "Cost sharing" means the total of any deductible, copayment, or coinsurance amounts imposed on a person covered under a policy or plan.

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

2. Every disability insurance policy and self–insured health plan that cover insulin and impose cost sharing on prescription drugs may not impose cost sharing on insulin in an amount that exceeds $50 for a one–month supply of insulin.

3. Nothing in this paragraph prohibits a disability insurance policy or self–insured health plan from imposing cost sharing on insulin in an amount less than the amount specified under subd. 2. Nothing in this paragraph requires a disability insurance policy or self–insured health plan to impose any cost sharing on insulin.

SECTION 412zL. 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 412zm. 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 and who have attained the age of 6 months but have not attained the age of 12 months.

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

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

24. Gonorrhea prophylaxis treatment for newborns.

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

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

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

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

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

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

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

32. Screening for critical congenital health defects for newborns.

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

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

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

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

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

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

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

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

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

42. Developmental screening and surveillance for minors including newborns.

43. Psychosocial and behavioral assessment for minors including newborns.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) 1. If an office visit and a preventive service specified under par. (b) are billed separately by the health care provider, the disability insurance policy or self–insured

health plan may apply deductibles to and impose copayments or coinsurance on the office visit but not on the preventive service.

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

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

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

SECTION 412zn. 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 412zp. 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 412zq. 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 412zr. 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 412zs. 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 412zt. 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 412zu. 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 412zv. 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 412zw. 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 412zx. 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.".

101. Page 355, line 20: after that line insert:

"**SECTION 417h.** 2017 Wisconsin Act 370, section 44 (5) is repealed.".

102. Page 388, line 14: delete "$20,000,000" and substitute "$15,000,000".

103. Page 388, line 16: delete "$20,000,000" and substitute "$15,000,000".

104. Page 389, line 6: delete "$7,584,400" and substitute "$4,740,300".

105. Page 389, line 8: delete "$23,557,700" and substitute "$14,875,100".

106. Page 387, line 14: delete lines 14 to 19 and substitute:

"(2) SURGICAL QUALITY IMPROVEMENT GRANT. From the appropriation under s. 20.435 (1) (b), the department of health services may award a onetime grant of $335,000 in fiscal year 2021–22 to support surgical quality improvement activities. Notwithstanding ss. 20.001 (3) (a) and 20.002 (1), the department of health services may transfer moneys appropriated for the purpose described under this subsection from fiscal year 2021–22 to fiscal year 2022–23.".

107. Page 389, line 10: after that line insert:

"(7h) BEHAVIORAL TREATMENT RATE INCREASE. The department of health services shall increase reimbursement rates for behavioral treatment services related to autism under the Medical Assistance program by 25 percent.

(7i) NURSING HOME GRANT PROGRAM. The authorized FTE positions for the department of health services are increased by 1.0 PR position on July 1, 2021, to be

funded from the appropriation under s. 20.435 (6) (g), for the purposes of managing the civil money penalties grant program.

(8h) COMMUNITY-BASED PSYCHOSOCIAL SERVICES. The department of health services may promulgate rules, including amending rules promulgated under s. 49.45 (30e) (b), update Medical Assistance program policies, and request any state plan amendment or waiver of federal Medicaid law from the federal government necessary to provide reimbursement to providers who are not county–based providers for psychosocial services provided to Medical Assistance recipients under s. 49.45 (30e).

(9h) TAILORED CAREGIVER ASSESSMENT AND REFERRAL PILOT PROGRAM. During fiscal year 2021–22, the department of health services shall conduct a one–year tailored caregiver assessment and referral pilot program as described in the September 2020 report of the governor's task force on caregiving.

(10h) INITIAL TRAINING FOR GUARDIANS. The grantee selected under s. 46.977 to administer and conduct training shall, no later than one year after the effective date of this subsection and in coordination with the department of health services, develop the content for the initial training to be provided to guardians under s. 54.26 and implement the program.

(11h) HEALTH INFORMATION EXCHANGE. From the appropriation under s. 20.435 (1) (b), the department of health services shall provide a grant of $655,000 in fiscal year 2021–22 and a grant of $655,000 in fiscal year 2022–23 to support health information exchange activities. The department of health services may not encumber moneys from the appropriation under s. 20.435 (1) (b) for a grant under this subsection after June 30, 2023. Notwithstanding ss. 20.001 (3) (a) and 20.002

(1), the department may transfer moneys appropriated for the purpose described under this subsection between fiscal years.

(12h) SPINAL CORD INJURY COUNCIL; INITIAL APPOINTMENTS. Notwithstanding the length of terms specified for the members of the spinal cord injury council under s. 15.197 (20) (a) (intro.), initial appointments to the council shall be made as follows:

(a) The members appointed under s. 15.197 (20) (a) 1., 3., 5., and 7., or in lieu of those members under s. 15.197 (20) (b), shall be appointed for terms expiring on July 1, 2024.

(b) The members appointed under s. 15.197 (20) (a) 2., 4., 6., and 8., or in lieu of those members under s. 15.197 (20) (b), shall be appointed for terms expiring on July 1, 2025.

(13h) BLACK WOMEN'S HEALTH. The department of health services shall award a grant of $500,000 in fiscal year 2021–22 and a grant of $500,000 in fiscal year 2022–23 to an entity to connect and convene efforts between state agencies, public and private sector organizations, and community organizations to support a statewide public health strategy to advance Black women's health. The department of health services may award the grants from the appropriation under s. 20.435 (1) (b).

(14h) CRISIS URGENT CARE AND OBSERVATION CENTER EMERGENCY RULES. The department of health services may promulgate rules allowed under s. 51.036 related to crisis urgent care and observation centers as emergency rules under s. 227.24. Notwithstanding s. 227.24 (1) (a) and (3), the department of health services is not required to provide evidence that promulgating a rule under this subsection 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 subsection.

(15h) CHILDLESS ADULTS DEMONSTRATION PROJECT. The department of health services shall submit any necessary request to the federal department of health and human services for a state plan amendment or waiver of federal Medicaid law or to modify or withdraw from any waiver of federal Medicaid law relating to the childless adults demonstration project under s. 49.45 (23), 2019 stats., to reflect the incorporation of recipients of Medical Assistance under the demonstration project into the BadgerCare Plus program under s. 49.471 and the termination of the demonstration project. Sections 20.940 and 49.45 (2t) do not apply to a submission to the federal government under this subsection.

(16h) MEDICAL ASSISTANCE REIMBURSEMENT RATE; EMERGENCY PHYSICIAN. For dates of service beginning on January 1, 2022, the department of health services shall increase by 36 percent the rates for emergency physician services under the Medical Assistance program.

(17h) OPTION TO PURCHASE PUBLICLY ADMINISTERED COVERAGE. During the 2021–23 fiscal biennium, the department of health services, the office of the commissioner of insurance, or the department of health services in consultation with the office of the commissioner of insurance shall conduct an analysis and actuarial study of the creation of an option for individuals to purchase health coverage that is publicly provided or administered. The analysis under this subsection shall incorporate input from a variety of persons and entities, including consumers, that have an interest in health insurance and health coverage, including Medical Assistance program coverage, and an analysis of any other health care affordability initiatives. If the department of health services or the office of the commissioner of

insurance determines that the option to purchase public coverage or any other health care affordability initiatives are feasible, the department or office may submit to the federal government any requests for a waiver of federal law or other federal approval necessary to implement the public coverage option or any other health care affordability initiatives. If the department of health services or office of the commissioner of insurance obtains the necessary federal approval or determines that no federal approval is necessary and if the department or office continues to determine that the option to purchase public coverage or any other health care affordability initiative is feasible, the department or office shall implement the option to purchase public coverage or other health care affordability initiative by January 1, 2025, or earlier if possible, except that if the commissioner of insurance determines the provisions of title I of the federal Patient Protection and Affordable Care Act, P.L. 111–148, are no longer enforceable, the department or office shall implement the public option or other affordability initiatives by January 1, 2022, or as soon as possible.

(18h) ADDICTION TREATMENT PLATFORM. From the appropriation under s. 20.435 (5) (a), the department of health services shall contract in fiscal year 2022–23 for the development of a substance use disorder treatment platform that allows for the comparison of substance use disorder treatment programs in the state. The department of health services may expend no more than $300,000 in fiscal year 2022–23 under this subsection.

SECTION 9123. Nonstatutory provisions; Insurance.

(1h) PRESCRIPTION DRUG COST SURVEY. The commissioner of insurance shall conduct a statistically valid survey of pharmacies in this state regarding whether the

pharmacy agreed to not disclose that customer drug benefit cost sharing exceeds the cost of the dispensed drug.

(2h) PUBLIC OPTION HEALTH INSURANCE PLAN. The office of the commissioner of insurance may expend from the appropriation under s. 20.145 (1) (a) in fiscal year 2021–22 not more than $900,000 for the development of a public option health insurance plan.

(3h) HEALTH INSURANCE PREMIUM ASSISTANCE PROGRAM. The commissioner of insurance shall develop a program to provide, beginning no later than plan year 2024, health insurance premium assistance to any resident of this state who purchases a silver level plan on the exchange, as defined in s. 628.90 (1), and whose household income exceeds 133 percent of the poverty line before application of the 5 percent income disregard as described in 42 CFR 435.603 (d), but does not exceed 250 percent of the poverty line. The assistance shall equal the difference between the lowest–cost silver level plan and lowest–cost bronze level plan in the individual's county of residence. The commissioner of insurance shall include a cost estimate of the program with the 2023–24 biennial budget submission for the office of the commissioner of insurance. In this subsection, "bronze level plan" means a plan described in 42 USC 18022 (d) (1) (A), "poverty line" means the poverty line as defined and revised annually under 42 USC 9902 (2) for a family the size of the individual's family, and "silver level plan" means a plan described in 42 USC 18022 (d) (1) (B).

(4h) PRESCRIPTION DRUG PURCHASING ENTITY. During the 2021–2023 fiscal biennium, the office of the commissioner of insurance shall conduct a study on the viability of creating or implementing a state prescription drug purchasing entity.

(5h) SCHOOL DISTRICT GROUP HEALTH INSURANCE TASK FORCE.

(a) The commissioner of insurance shall establish a committee called the "School District Group Health Insurance Task Force." The task force shall consist of the following members appointed by the governor:

1. One representative from the office of the commissioner of insurance.

2. One representative from the department of administration.

3. One representative from the department of public instruction.

4. One representative from the department of employee trust funds.

5. One administrator of a school district.

6. One business official of a school district.

7. One member of a school board.

8. One official of a public employee union.

9. Three employees of public schools.

10. One representative of a health plan.

(b) The representative from the office of the commissioner of insurance shall be the chairperson of the task force.

(c) Based on consultation with the task force, and review of an actuarial report by the group insurance board following a study of the potential costs and savings to school districts and current plan participants if all Wisconsin school districts are required to participate in a group health insurance plan offered by the group insurance board of this act, the commissioner of insurance and the secretary of employee trust funds shall develop an implementation plan, which, if enacted, would require all school districts in this state to participate in a group health insurance program offered by the group insurance board by January 1, 2024.

(d) The commissioner of insurance and the secretary of employee trust funds shall submit the implementation plan to the governor and the joint committee of finance by December 31, 2022.

(6h) PRESCRIPTION DRUG IMPORTATION PROGRAM. The commissioner of insurance shall submit the first report required under s. 601.575 (5) by the next January 1 or July 1, whichever is earliest, that is at least 180 days after the date the prescription drug importation program is fully operational under s. 601.575 (4). The commissioner of insurance shall include in the first 3 reports submitted under s. 601.575 (5) information on the implementation of the audit functions under s. 601.575 (1) (n).

(7h) STAGGERED TERMS FOR BOARD. Notwithstanding the length of terms specified for the members of the board under s. 15.735 (1) (b) to (e), 2 of the initial members shall be appointed for terms expiring on May 1, 2023; 2 of the initial members shall be appointed for terms expiring on May 1, 2024; 2 of the initial members shall be appointed for terms expiring on May 1, 2025; and 2 of the initial members shall be appointed for terms expiring on May 1, 2026.".

108. Page 396, line 1: delete lines 1 to 3.

109. Page 397, line 12: after that line insert:

"(1h) STATEMENTS OF GUARDIANS. The treatment of ss. 54.15 (8) (a) (intro.) (as it relates to any requirement for a statement as described under s. 54.15 (8) (a) 2m.) and 2m. and 54.26 first applies to petitions for guardianship filed on the first day of the 13th month beginning after the effective date of this subsection.

SECTION 9323. Initial applicability; Insurance.

(1h) APPLICATION OF MANUFACTURER DISCOUNTS.

(a) For policies and plans containing provisions inconsistent with the treatment of s. 632.862, the treatment of s. 632.862 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 or plans that are affected by a collective bargaining agreement containing provisions inconsistent with the treatment of s. 632.862, the treatment of s. 632.862 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 newly established, extended, modified, or renewed, whichever is later.

(2h) TELEHEALTH PARITY.

(a) For policies and plans containing provisions inconsistent with the treatment of s. 632.871, the treatment of s. 632.871 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 s. 632.871, the treatment of s. 632.871 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 newly established, extended, modified, or renewed, whichever is later.

(3h) 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.".

110. Page 398, line 23: after that line insert:

"(2h) MEDICAID EXPANSION. The treatment of ss. 20.435 (4) (jw), 49.45 (2p), (23), and (23b) (title), (b), (c), and (e), 49.471 (1) (cr), (4) (a) 4. b. and 8. and (4g), and 49.686 (3) (d) and SECTION 9119 (15h) of this act take effect on July 1, 2021.

SECTION 9423. Effective dates; Insurance.

(1h) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES. The treatment of ss. 40.51 (8) (by SECTION 180e) and (8m) (by SECTION 180h), 66.0137 (4) (by SECTION 238t), 120.13 (2) (g) (by SECTION 351n), 185.983 (1) (intro.) (by SECTION 363m), 609.713, 609.847, 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a) (by SECTION 412m), 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 (3h) of this act take effect on the first day of the 4th month beginning after publication.

(2h) PRESCRIPTION DRUG AFFORDABILITY REVIEW BOARD. The treatment of ss. 15.07 (3) (bm) 7., 15.735, 601.78, 601.785, and 601.79 and subch. VI (title) of chap. 601 takes effect on the first day of the 7th month after the day of publication.

(3h) COST-SHARING CAP FOR INSULIN. The treatment of ss. 609.83 (by SECTION 412f) and 632.895 (6) (title), the renumbering and amendment of s. 632.895 (6), and the creation of s. 632.895 (6) (b) take effect on the first day of the 4th month beginning after publication.”.

(END)

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