State of Wisconsin
2025 - 2026 LEGISLATURE

LRBb0629/1
ALL:all

SENATE AMENDMENT 4,

TO SENATE SUBSTITUTE AMENDMENT 2,

TO SENATE BILL 45

July 2, 2025 - Offered by Senators HESSELBEIN, SMITH, SPREITZER, DRAKE, L. JOHNSON, ROYS, CARPENTER, DASSLER-ALFHEIM, HABUSH SINYKIN, KEYESKI, LARSON, PFAFF, RATCLIFF and WALL.

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

1. At the appropriate places, insert all of the following:

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

20.435 **(1)** (ck) *Emergency medical services grants.* The amounts in the schedule for grants to municipalities to improve or expand emergency medical services under s. 256.42.

SECTION 2. 20.435 (1) (ef) of the statutes is amended to read:

20.435 **(1)** (ef) *Lead-poisoning or lead-exposure services.* ~~The~~ As a continuing appropriation, the amounts in the schedule for the purposes of providing grants under s. 254.151.

SECTION 3. 20.435 (1) (fi) of the statutes is repealed.

SECTION 4. 20.435 (1) (fk) of the statutes is amended to read:

20.435 **(1)** (fk) *Grants to establish ~~advanced practice clinician~~ health care provider training programs.* Biennially, the amounts in the schedule for grants to hospitals, health systems, clinics, and educational entities that form health care education and training consortia under s. 146.615.

SECTION 5. 20.435 (2) (g) of the statutes is amended to read:

20.435 **(2)** (g) *Alternative services of institutes and centers.* All moneys received as payments for services under ss. 46.043 and 51.06 (1r) and (5) for provision of alternative services by mental health institutes under s. 46.043 and by centers for the developmentally disabled under s. 51.06 (1r).

SECTION 6. 20.435 (2) (gk) of the statutes is amended to read:

20.435 **(2)** (gk) *Institutional operations and charges.* The amounts in the schedule for care, other than under s. 51.06 (1r), provided by the centers for the developmentally disabled, to reimburse the cost of providing the services and to remit any credit balances to county departments that occur on and after July 1, 1978, in accordance with s. 51.437 (4rm) (c); for care, other than under s. 46.043, provided by the mental health institutes, to reimburse the cost of providing the services and to remit any credit balances to county departments that occur on and after January 1, 1979, in accordance with s. 51.42 (3) (as) 2.; for care of juveniles placed at the Mendota juvenile treatment center for whom counties are financially responsible under s. 938.357 (3) (d), to reimburse the cost of providing that care; for maintenance of state-owned housing at centers for the developmentally disabled and mental health institutes; for repair or replacement of property damaged at the mental health institutes or at centers for the

developmentally disabled; for reimbursing the total cost of using, producing, and providing services, products, and care; and to transfer to the appropriation account under sub. (5) (kp) for funding centers. All moneys received as payments from medical assistance on and after August 1, 1978; as payments from all other sources including other payments under s. 46.10 and payments under s. 51.437 (4rm) (c) received on and after July 1, 1978; as medical assistance payments, other payments under s. 46.10, and payments under s. 51.42 (3) (as) 2. received on and after January 1, 1979; as payments from counties for the care of juveniles placed at the Mendota juvenile treatment center; as payments for the rental of state-owned housing and other institutional facilities at centers for the developmentally disabled and mental health institutes; for the sale of electricity, steam, or chilled water; as payments in restitution of property damaged at the mental health institutes or at centers for the developmentally disabled; for the sale of surplus property, including vehicles, at the mental health institutes or at centers for the developmentally disabled; and for other services, products, and care shall be credited to this appropriation, except that any payment under s. 46.10 received for the care or treatment of patients admitted under s. 51.10, 51.15, or 51.20 for which the state is liable under s. 51.05 (3), of forensic patients committed under ch. 971 or 975, admitted under ch. 975, or transferred under s. 51.35 (3), or of patients transferred from a state prison under s. 51.37 (5), to the Mendota Mental Health Institute or the Winnebago Mental Health Institute shall be treated as general purpose revenue — earned, as defined under s. 20.001 (4); and except that moneys received under s. 51.06 (6) may be expended only as provided in s. 13.101 (17). All

moneys transferred under 2025 Wisconsin Act .... (this act), section 9219 (2), shall be credited to this appropriation account.

SECTION 7. 20.435 (2) (gL) of the statutes is repealed.

SECTION 8. 20.435 (4) (bm) of the statutes is amended to read:

20.435 **(4)** (bm) *Medical Assistance, food stamps, and Badger Care administration; contract costs, insurer reports, and resource centers.* Biennially, the amounts in the schedule to provide a portion of the state share of administrative contract costs for the Medical Assistance program under subch. IV of ch. 49 and the Badger Care health care program under s. 49.665 and to provide the state share of administrative costs for the food stamp program under s. 49.79, other than payments under s. 49.78 (8), to develop and implement a registry of recipient immunizations, to reimburse 3rd parties for their costs under s. 49.475, for costs associated with outreach activities, for state administration of state supplemental grants to supplemental security income recipients under s. 49.77, for grants under ss. 46.73 and 46.74, and for services of resource centers under s. 46.283. No state positions may be funded in the department of health services from this appropriation, except positions for the performance of duties under a contract in effect before January 1, 1987, related to the administration of the Medical Assistance program between the subunit of the department primarily responsible for administering the Medical Assistance program and another subunit of the department. Total administrative funding authorized for the program under s. 49.665 may not exceed 10 percent of the amounts budgeted under pars. (p) and (x).

SECTION 9. 20.435 (4) (bq) of the statutes is repealed.

SECTION 10. 20.435 (4) (bu) of the statutes is created to read:

20.435 **(4)** (bu) *Payment processing program for farmers.* Biennially, the amounts in the schedule to provide electronic benefit transfer and credit and debit card processing equipment and services to farmers' markets and farmers who sell directly to consumers under s. 49.79 (7s).

SECTION 11. 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 under s. 256.23 (6), 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, for administration of the hospital assessment under s. 50.38, and for administration of the ambulance service provider fee under s. 256.23.

SECTION 12. 20.435 (4) (pa) of the statutes is amended to read:

20.435 **(4)** (pa) *Federal aid; Medical Assistance and food stamp contracts administration.* All federal moneys received for the federal share of the cost of contracting for payment and services administration and reporting, other than moneys received under pars. (nn) and (np), to reimburse 3rd parties for their costs under s. 49.475, for administrative contract costs for the food stamp program under s. 49.79, for grants under ss. 46.73 and 46.74, and for services of resource centers under s. 46.283.

SECTION 13. 20.435 (5) (bw) of the statutes is amended to read:

20.435 **(5)** (bw) ~~*Child psychiatry and addiction medicine consultation programs*~~ *Mental health consultation program*. Biennially, the amounts in the schedule for operating the ~~child psychiatry consultation program under s. 51.442 and the addiction medicine consultation program under s. 51.448~~ mental health consultation program under s. 51.443.

SECTION 14. 20.435 (5) (bx) of the statutes is created to read:

20.435 **(5)** (bx) *Addiction medicine consultation program.* Biennially, the amounts in the schedule for operating the addiction medicine consultation program under s. 51.448.

SECTION 15. 20.435 (5) (ch) of the statutes is created to read:

20.435 **(5)** (ch) *Suicide and crisis lifeline grants.* The amounts in the schedule for grants under s. 46.533.

SECTION 16. 20.435 (5) (ck) of the statutes is amended to read:

20.435 **(5)** (ck) *Crisis urgent care and observation facilities.* ~~Biennially~~ As a continuing appropriation, the amounts in the schedule for grants to support crisis urgent care and observation facilities.

SECTION 17. 20.435 (5) (ct) of the statutes is repealed.

SECTION 18. 20.435 (5) (dg) of the statutes is created to read:

20.435 **(5)** (dg) *Grants for crisis stabilization facilities.* The amounts in the schedule for grants to facilities that provide crisis stabilization services under s. 51.03 (7).

SECTION 19. 20.940 of the statutes is repealed.

SECTION 20. 36.47 of the statutes is created to read:

36.47 Parkinson's disease registry. (1) DEFINITIONS. In this section:

(a) "Department" means the Population Health Institute, or its successor, at the University of Wisconsin-Madison School of Medicine and Public Health.

(a) "Health care facility" has the meaning given in s. 155.01 (6).

(b) "Health care provider" means a physician, surgeon, physician assistant, or nurse practitioner.

(c) "Parkinsonism" means a condition that causes a combination of the movement abnormalities seen in Parkinson's disease, including tremor at rest, slow movements, muscle rigidity, stooped posture, or unsteady or shuffling gait, which often overlap with and can evolve from what appears to be Parkinson's disease. "Parkinsonism" includes multiple system atrophy, dementia with Lewy bodies, corticobasal degeneration, and progressive supranuclear palsy.

(d) "Parkinson's disease" means a chronic and progressive neurologic disorder resulting from deficiency of the neurotransmitter dopamine as the consequence of specific degenerative changes in the basal ganglia, which is characterized by tremor at rest, slow movements, muscle rigidity, stooped posture, and unsteady or shuffling gait.

(2) CONSULTATION BY THE DEPARTMENT OF HEALTH SERVICES. The department of health services may do all of the following:

(a) Assist the department in the establishment and maintenance of a Parkinson's disease registry, as provided under sub. (3).

(b) Make recommendations to the department on the data to be collected in the Parkinson's disease registry.

(c) Advise the department on the Parkinson's disease registry.

(d) Make recommendations to the department on the best practices for the establishment of the Parkinson's disease registry under sub. (3).

(3) PARKINSON'S DISEASE REGISTRY. (a) By no later than the first day of the 19th month beginning after the effective date of this paragraph .... [LRB inserts date], the department shall, after consultation with the department of health services, establish and maintain a Parkinson's disease registry for the collection, storage, and dissemination of information about the incidence and prevalence of Parkinson's disease and parkinsonisms in this state.

(b) The department shall collect and store in the Parkinson's disease registry data reported under s. 255.18 (2) by health care providers and health care facilities.

(c) The department shall prescribe the format for reporting information to the department under s. 255.18 (2).

(d) The department shall create, and regularly review and revise, a list of information that health care providers and health care facilities must report, subject to s. 255.18 (2) (d), to the department under s. 255.18 (2). The list shall include the incident of a patient's Parkinson's disease or parkinsonism; necessary triggering diagnostic conditions, consistent with the latest version of the International Statistical Classification of Diseases and Related Health Problems; resulting case data on issues including diagnosis, treatment, and survival; and patient demographic information, including age, gender, and race. The Board of Regents of the University of Wisconsin System may promulgate rules to implement and administer this paragraph.

(e) The University of Wisconsin-Madison may enter into agreements in order for the department to securely and confidentially receive information from data

reporting entities and their associated electronic medical records vendors related to Parkinson's disease testing, diagnosis, and treatment.

(f) 1. The University of Wisconsin-Madison may enter into agreements in order for the department to disclose data collected in the Parkinson's disease registry to another state's Parkinson's disease registry, a federal Parkinson's disease control agency, a local health officer, or a researcher who proposes to conduct research on Parkinson's disease.

2. Before disclosing data containing confidential information to an entity under subd. 1., the University of Wisconsin-Madison shall require the entity to specify the purpose for the requested disclosure, agree in writing to maintain the confidentiality of the information and, if the entity is a researcher, provide all of the following to the University of Wisconsin-Madison:

a. A written protocol to perform research.

b. Documentation of approval of the research protocol by an institutional review board of a domestic institution that has a federalwide assurance approved by the office for human research protections of the federal department of health and human services.

c. Documentation that demonstrates to the University of Wisconsin-Madison's satisfaction that the researcher has established procedures and has the capability to maintain the confidentiality of the information.

(4) WEBSITE. (a) By no later than the first day of the 19th month beginning after the effective date of this paragraph .... [LRB inserts date], the department shall establish and maintain a public website dedicated to the Parkinson's disease

registry under sub. (3). The department shall include on the website all of the following:

1. Downloadable annual reports on the incidence and prevalence of Parkinson's disease in this state.

2. Relevant data, as determined by the department, about Parkinson's disease and parkinsonisms for the 5-year period prior to the effective date of this subdivision .... [LRB inserts date].

3. Other helpful resources about Parkinson's disease, as determined by the department.

(b) By no later than January 1 of each year, the department shall update the information specified in par. (a) 1. on the website maintained under par. (a).

(c) The department shall publish on its website notice of the reporting requirement under s. 255.18 no fewer than 90 days before the reporting requirement takes effect.

(5) CONFIDENTIALITY. (a) Any information reported to the department under s. 255.18 (2) that could identify an individual who is the subject of the report or a health care provider submitting the report is confidential.

(b) To ensure privacy, the department shall use a coding system for the data stored in the Parkinson's disease registry that removes any identifying information about an individual who is the subject of a report under s. 255.18.

(c) 1. If the University of Wisconsin-Madison or the department discloses confidential information as authorized under sub. (3) (f), the University of Wisconsin-Madison or department may include in the disclosure only the information necessary for the purpose specified under sub. (3) (f) 2.

2. A person who obtains confidential information from the University of Wisconsin-Madison or the department under sub. (3) (f) may use the information only for the purpose specified under sub. (3) (f) 2. and may not redisclose the information.

(d) The department shall maintain an accurate record of all persons given access to confidential information under this section. The record shall include all of the following:

1. The name of the person authorizing access.

2. The title, address, and organizational affiliation of any person given access.

3. The dates of access.

4. The specific purpose for which the information is to be used.

(e) The department shall make the records maintained under par. (d) available for public inspection during the department's normal operating hours.

(f) Confidential information under this section is not available for subpoena and may not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding. Confidential information under this section is not admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason.

SECTION 21. 40.03 (6) (a) 1. of the statutes is amended to read:

40.03 **(6)** (a) 1. ~~Except as provided in par. (m), shall~~ Shall, on behalf of the state, enter into a contract or contracts with one or more insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans provided for by this chapter; or

SECTION 22. 40.03 (6) (a) 2. of the statutes is amended to read:

40.03 **(6)** (a) 2. ~~Except as provided in par. (m), may~~ May, wholly or partially in lieu of subd. 1., on behalf of the state, provide any group insurance plan on a self-insured basis in which case the group insurance board shall approve a written description setting forth the terms and conditions of the plan, and may contract directly with providers of hospital, medical or ancillary services to provide insured employees with the benefits provided under this chapter.

SECTION 23. 40.03 (6) (b) of the statutes is amended to read:

40.03 **(6)** (b) ~~Except as provided in par. (m), may~~ May provide other group insurance plans for employees and their dependents and for annuitants and their dependents in addition to the group insurance plans specifically provided under this chapter. The terms of the group insurance under this paragraph shall be determined by contract, and shall provide that the employer is not liable for any obligations accruing from the operation of any group insurance plan under this paragraph except as agreed to by the employer.

SECTION 24. 40.03 (6) (m) of the statutes is repealed.

SECTION 25. 40.51 (9m) of the statutes is created to read:

40.51 **(9m)** Every health care coverage plan offered by the state under sub. (6) and every health care coverage plan offered by the group insurance board under sub. (7) shall, if the health care coverage plan provides maternity coverage, provide coverage for abortion and any other medical services necessary to provide abortion.

SECTION 26. 40.56 of the statutes is repealed.

SECTION 27. 46.245 of the statutes is repealed.

SECTION 28. 46.275 (5) (e) of the statutes is repealed.

SECTION 29. 46.40 (8) of the statutes is amended to read:

46.40 **(8)** ALZHEIMER'S FAMILY AND CAREGIVER SUPPORT ALLOCATION. Subject to sub. (9), the department cannot distribute more than ~~$3,058,900~~ $3,558,900 in each fiscal year for services to persons with Alzheimer's disease and their caregivers under s. 46.87.

SECTION 30. 46.48 (16) of the statutes is created to read:

46.48 **(16)** ASSISTIVE TECHNOLOGY. The department may distribute not more than $250,000 in each fiscal year for grants to provide assistive technology services.

SECTION 31. 46.48 (21) of the statutes is created to read:

46.48 **(21)** TRAUMA RESILIENCE GRANT. The department may distribute not more than $250,000 in fiscal year 2025-26 and not more than $250,000 in fiscal year 2026-27 as a grant to an organization in the city of Milwaukee to support the needs of individuals impacted by trauma and to develop the capacity of organizations to treat and prevent trauma.

SECTION 32. 46.48 (21) of the statutes, as created by 2025 Wisconsin Act .... (this act), is repealed.

SECTION 33. 46.48 (24) of the statutes is created to read:

46.48 **(24)** PEDIATRIC HEALTH PSYCHOLOGY RESIDENCY AND FELLOWSHIP TRAINING PROGRAMS. The department may distribute not more than $600,000 in each fiscal year as grants to support pediatric health psychology residency and fellowship training programs.

SECTION 34. 46.48 (27) of the statutes is created to read:

46.48 **(27)** COMMUNITY-BASED WITHDRAWAL MANAGEMENT CENTERS. From the appropriation under s. 20.435 (5) (bc), the department shall distribute not more than $500,000 in each fiscal year for grants to community-based withdrawal

centers, including those certified as an adult residential integrated behavioral health stabilization service, residential intoxication monitoring service, or residential withdrawal management service, as those terms are defined under s. 49.45 (30p) (a) 1., 4., and 5.

SECTION 35. 46.48 (33) of the statutes is created to read:

46.48 **(33)** DIAPER BANK GRANTS. The department may distribute not more than $500,000 in each fiscal year as grants to diaper banks to provide diapers to families in need.

SECTION 36. 46.48 (34) of the statutes is created to read:

46.48 **(34)** MATERNAL AND CHILD HEALTH. The department may distribute not more than $800,000 in each fiscal year as grants to local and community-based organizations whose mission is to improve maternal and child health in this state.

SECTION 37. 46.48 (35) of the statutes is created to read:

46.48 **(35)** PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES. The department may distribute not more than $1,790,000 in each fiscal year to support psychiatric residential treatment facilities under s. 51.044.

SECTION 38. 46.482 (1) (a) of the statutes is renumbered 46.482 (1) (bm).

SECTION 39. 46.482 (1) (am) of the statutes is created to read:

46.482 **(1)** (am) "Certified peer specialist" means an individual described under s. 49.45 (30j) (a) 1m. who has met the certification requirements established by the department.

SECTION 40. 46.482 (1) (b) of the statutes is renumbered 46.482 (1) (c) and amended to read:

46.482 **(1)** (c) "Peer recovery coach" means an individual described under s.

49.45 (30j) (a) ~~2.~~ 3. who has completed the training requirements specified under s. 49.45 (30j) (b) 4.

SECTION 41. 46.482 (2) (a) of the statutes is amended to read:

46.482 **(2)** (a) Use peer recovery coaches and certified peer specialists to encourage individuals to seek treatment for a substance use disorder following an overdose.

SECTION 42. 46.482 (2) (f) of the statutes is amended to read:

46.482 **(2)** (f) Collect and evaluate data on the outcomes of patients receiving peer recovery coach or certified peer specialist services and coordination and continuation of care services under this section.

SECTION 43. 46.533 of the statutes is created to read:

46.533 Suicide and crisis lifeline; grants. (1) In this section, "national crisis hotline" means the telephone or text access number "988," or its successor, that is maintained under the federally administered program under 42 USC 290bb-36c.

(2) From the appropriation under s. 20.435 (5) (ch), the department shall award grants to organizations that provide crisis intervention services and crisis care coordination to individuals who contact the national crisis hotline from anywhere within this state.

SECTION 44. 46.536 (1) of the statutes is renumbered 46.536 (1) (intro.) and amended to read:

46.536 **(1)** (intro.) From the appropriation under s. 20.435 (5) (cf), the department shall award all of the following grants ~~in the~~:

(a) A 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 or counties, municipalities, or regions comprised of multiple counties or municipalities to establish and enhance law enforcement and behavioral health services emergency response collaboration programs. Grant recipients under this ~~section~~ paragraph shall match at least 25 percent of the grant amount awarded for the purpose that the grant is received. The department may not award any single grant in an amount greater than $100,000.

SECTION 45. 46.536 (1) (b) of the statutes is created to read:

46.536 **(1)** (b) A total amount of $2,000,000 in each fiscal biennium to counties, regions comprised of multiple counties, or municipalities to establish and enhance law enforcement and behavioral health services emergency response collaboration programs. Grant recipients under this paragraph shall match at least 25 percent of the grant amount awarded for the purpose that the grant is received.

SECTION 46. 46.73 of the statutes is created to read:

46.73 Community dental health coordinators. From the appropriations under s. 20.435 (4) (bm) and (pa), the department shall award grants to support community dental health coordinators in rural regions of the state.

SECTION 47. 46.74 of the statutes is created to read:

46.74 Grants for mobile dental clinics. The department shall award grants to community health centers, as defined in s. 250.15 (1) (a), to procure and operate mobile dental clinics.

SECTION 48. 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.

SECTION 49. 48.375 (4) (a) 1. of the statutes is amended to read:

48.375 **(4)** (a) 1. The person or the person's agent has, either directly or through a referring physician or his or her agent, received and made part of the minor's medical record~~, under the requirements of s. 253.10,~~ the voluntary and informed written consent of the minor and the voluntary and informed written consent of one of her parents; or of the minor's guardian or legal custodian, if one has been appointed; or of an adult family member of the minor; or of one of the minor's foster parents, if the minor has been placed in a foster home and the minor's parent has signed a waiver granting the department, a county department, or the foster parent the authority to consent to medical services or treatment on behalf of the minor.

SECTION 50. 49.45 (2p) of the statutes is repealed.

SECTION 51. 49.45 (2t) of the statutes is repealed.

SECTION 52. 49.45 (3h) of the statutes is created to read:

49.45 **(3h)** PAYMENTS TO RURAL HEALTH CLINICS. (a) For services provided by a rural health clinic on or after the effective date of this paragraph .... [LRB inserts date], and before July 1, 2026, to a recipient of the Medical Assistance program under this subchapter, the department shall reimburse the rural health clinic under a payment methodology in effect on July 1, 2025, and in accordance with 42 USC 1396a (bb) (6).

(b) For services provided by a rural health clinic on or after July 1, 2026, to a recipient of the Medical Assistance program under this subchapter, the department shall reimburse the rural health clinic using a payment methodology based on the Medicaid prospective payment system under 42 USC 1396a (bb) (1) to (3). The department shall consult with rural health clinics in developing the payment methodology under this paragraph.

SECTION 53. 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 in 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 subdivision, 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), 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 54. 49.45 (19) (a) of the statutes is amended to read:

49.45 **(19)** (a) As a condition of eligibility for medical assistance, a person

shall, notwithstanding other provisions of the statutes except as provided in par. (cm), be deemed to have assigned to the state, by applying for or receiving medical assistance, any rights to medical support or other payment of medical expenses from any other person, including rights to unpaid amounts accrued at the time of application for medical assistance as well as any rights to support accruing during the time for which medical assistance is paid.

SECTION 55. 49.45 (19) (c) of the statutes is repealed.

SECTION 56. 49.45 (19) (cm) of the statutes is created to read:

49.45 **(19)** (cm) Notwithstanding par. (a), birth expenses may not be recovered by the state under this subsection.

SECTION 57. 49.45 (23) of the statutes is repealed.

SECTION 58. 49.45 (23b) of the statutes is repealed.

SECTION 59. 49.45 (24k) (c) of the statutes is repealed.

SECTION 60. 49.45 (24L) of the statutes is created to read:

49.45 **(24L)** STATEWIDE DENTAL CONTRACT. The department 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 to implement a statewide contract for dental benefits through a single vendor under the Medical Assistance program. If the federal government disapproves the amendment or waiver request, the department is not required to implement this subsection.

SECTION 61. 49.45 (25c) of the statutes is created to read:

49.45 **(25c)** CHILDREN'S BEHAVIORAL HEALTH SPECIALTY MANAGED CARE. The department may request a waiver from the federal department of health and human services to administer a children's behavioral health specialty managed

care program under the Medical Assistance program. If the waiver is granted, the department may administer the children's behavioral health specialty managed care program under this subsection.

SECTION 62. 49.45 (25d) of the statutes is created to read:

49.45 **(25d)** HEALTH-RELATED SOCIAL NEEDS. The department shall request a waiver from the federal department of health and human services to provide reimbursement for services for health-related social needs under the Medical Assistance program. If the waiver is granted, the department shall provide reimbursement for services for health-related social needs under this subsection.

SECTION 63. 49.45 (30) (a) of the statutes is repealed.

SECTION 64. 49.45 (30) (b) of the statutes is renumbered 49.45 (30) and amended to read:

49.45 **(30)** SERVICES PROVIDED BY COMMUNITY SUPPORT PROGRAMS. The department shall reimburse a ~~provider of~~ county that provides services under s. 49.46 (2) (b) 6. L. ~~only~~ 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 for those services under the Medical Assistance program that is not provided by the federal government.

SECTION 65. 49.45 (30j) (title) of the statutes is amended to read:

49.45 **(30j)** (title) REIMBURSEMENT FOR PEER RECOVERY COACH AND CERTIFIED PEER SPECIALIST SERVICES.

SECTION 66. 49.45 (30j) (a) 1. and 2. of the statutes are renumbered 49.45 (30j) (a) 2m. and 3.

SECTION 67. 49.45 (30j) (a) 1m. of the statutes is created to read:

49.45 **(30j)** (a) 1m. "Certified peer specialist" means an individual who has experience in the mental health and substance use services system, who is trained to provide support to others, and who has received peer specialist or parent peer specialist certification under the rules established by the department.

SECTION 68. 49.45 (30j) (bm) of the statutes is created to read:

49.45 **(30j)** (bm) The department shall reimburse under the Medical Assistance program under this subchapter any service provided by a certified peer specialist if the service satisfies all of the following conditions:

1. The recipient of the service provided by a certified peer specialist is in treatment for or recovery from a mental illness or a substance use disorder.

2. The certified peer specialist provides the service under the supervision of a competent mental health professional.

3. The certified peer specialist provides the service in coordination with the Medical Assistance recipient's individual treatment plan and in accordance with the recipient's individual treatment goals.

4. The certified peer specialist providing the service has completed training requirements, as established by the department by rule, after consulting with members of the recovery community.

SECTION 69. 49.45 (30j) (c) of the statutes is amended to read:

49.45 **(30j)** (c) The department shall certify under Medical Assistance peer recovery coaches and certified peer specialists to provide services in accordance with this subsection.

SECTION 70. 49.45 (30p) of the statutes is created to read:

49.45 **(30p)** DETOXIFICATION AND STABILIZATION SERVICES. (a) In this subsection:

1. "Adult residential integrated behavioral health stabilization service" means a residential behavioral health treatment service, delivered under the oversight of a medical director, that provides withdrawal management and intoxication monitoring, as well as integrated behavioral health stabilization services, and includes nursing care on site for medical monitoring available on a 24-hour basis. "Adult residential integrated behavioral health stabilization service" may include the provision of services including screening, assessment, intake, evaluation and diagnosis, medical care, observation and monitoring, physical examination, determination of medical stability, medication management, nursing services, case management, drug testing, counseling, individual therapy, group therapy, family therapy, psychoeducation, peer support services, recovery coaching, recovery support services, and crisis intervention services, to ameliorate acute behavioral health symptoms and stabilize functioning.

2. "Community-based withdrawal management" means a medically managed withdrawal management service delivered on an outpatient basis by a physician or other service personnel acting under the supervision of a physician.

3. "Detoxification and stabilization services" means adult residential integrated behavioral health stabilization service, residential withdrawal management service, or residential intoxication monitoring service.

4. "Residential intoxication monitoring service" means a residential service that provides 24-hour observation to monitor the safe resolution of alcohol or

sedative intoxication and to monitor for the development of alcohol withdrawal for intoxicated patients who are not in need of emergency medical or behavioral health care. "Residential intoxication monitoring service" may include the provision of services including screening, assessment, intake, evaluation and diagnosis, observation and monitoring, case management, drug testing, counseling, individual therapy, group therapy, family therapy, psychoeducation, peer support services, recovery coaching, and recovery support services.

5. "Residential withdrawal management service" means a residential substance use treatment service that provides withdrawal management and intoxication monitoring, and includes medically managed 24-hour on-site nursing care, under the supervision of a physician. "Residential withdrawal management service" may include the provision of services, including screening, assessment, intake, evaluation and diagnosis, medical care, observation and monitoring, physical examination, medication management, nursing services, case management, drug testing, counseling, individual therapy, group therapy, family therapy, psychoeducation, peer support services, recovery coaching, and recovery support services, to ameliorate symptoms of acute intoxication and withdrawal and to stabilize functioning. "Residential withdrawal management service" may also include community-based withdrawal management and intoxication monitoring services.

(b) Subject to par. (c), the department shall provide reimbursement for detoxification and stabilization services under the Medical Assistance program under s. 49.46 (2) (b) 14r. The department shall certify providers under the Medical

Assistance program to provide detoxification and stabilization services in accordance with this subsection.

(c) 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 detoxification and stabilization services as described in this subsection. If the federal department approves the request or if no federal approval is necessary, the department shall provide the reimbursement under s. 49.46 (2) (b) 14r. If the federal department disapproves the request, the department may not provide the reimbursement described in this subsection.

SECTION 71. 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.

SECTION 72. 49.45 (39) (b) 1. of the statutes is amended to read:

49.45 **(39)** (b) 1. 'Payment for school medical services.' If a school district or a cooperative educational service agency elects to provide school medical services and meets all requirements under par. (c), the department shall reimburse the school district or the cooperative educational service agency for ~~60~~ 100 percent of the federal share of allowable charges for the school medical services that it provides and, as specified in subd. 2., for allowable administrative costs. If the Wisconsin Center for the Blind and Visually Impaired or the Wisconsin Educational Services Program for the Deaf and Hard of Hearing elects to provide school medical services and meets all requirements under par. (c), the department shall reimburse the department of public instruction for ~~60~~ 100 percent of the federal share of allowable charges for the school medical services that the Wisconsin Center for the Blind and Visually Impaired or the Wisconsin Educational Services Program for the Deaf and Hard of Hearing provides and, as specified in subd. 2., for allowable administrative costs. A school district, cooperative educational service agency, the Wisconsin Center for the Blind and Visually Impaired, or the Wisconsin Educational Services Program for the Deaf and Hard of Hearing may submit, and the department shall allow, claims for common carrier transportation costs as a school medical service unless the department receives notice from the federal health care financing administration that, under a change in federal policy, the claims are not allowed. If the department receives the notice, a school district, cooperative educational service

agency, the Wisconsin Center for the Blind and Visually Impaired, or the Wisconsin Educational Services Program for the Deaf and Hard of Hearing may submit, and the department shall allow, unreimbursed claims for common carrier transportation costs incurred before the date of the change in federal policy. The department shall promulgate rules establishing a methodology for making reimbursements under this paragraph. All other expenses for the school medical services provided by a school district or a cooperative educational service agency shall be paid for by the school district or the cooperative educational service agency with funds received from state or local taxes. The school district, the Wisconsin Center for the Blind and Visually Impaired, the Wisconsin Educational Services Program for the Deaf and Hard of Hearing, or the cooperative educational service agency shall comply with all requirements of the federal department of health and human services for receiving federal financial participation.

SECTION 73. 49.45 (39) (b) 2. of the statutes is amended to read:

49.45 **(39)** (b) 2. 'Payment for school medical services administrative costs.' The department shall reimburse a school district or a cooperative educational service agency specified under subd. 1. and shall reimburse the department of public instruction on behalf of the Wisconsin Center for the Blind and Visually Impaired or the Wisconsin Educational Services Program for the Deaf and Hard of Hearing for ~~90~~ 100 percent of the federal share of allowable administrative costs, using time studies~~, beginning in fiscal year 1999-2000~~. A school district or a cooperative educational service agency may submit, and the department of health

services shall allow, claims for administrative costs incurred during the period that is up to 24 months before the date of the claim, if allowable under federal law.

SECTION 74. 49.45 (41) (d) of the statutes is amended to read:

49.45 **(41)** (d) The department shall~~, in accordance with all procedures set forth under s. 20.940,~~ request a waiver under 42 USC 1315 or submit a Medical Assistance state plan amendment to the federal department of health and human services to obtain any necessary federal approval required to provide reimbursement to crisis urgent care and observation facilities certified under s. 51.036 for crisis intervention services under this subsection. ~~If the department determines submission of a state plan amendment is appropriate, the department shall, notwithstanding whether the expected fiscal effect of the amendment is $7,500,000 or more, submit the amendment to the joint committee on finance for review in accordance with the procedures under sub. (2t).~~ If federal approval is granted or no federal approval is required, the department shall provide reimbursement under s. 49.46 (2) (b) 15. If federal approval is necessary but is not granted, the department may not provide reimbursement for crisis intervention services provided by crisis urgent care and observation facilities.

SECTION 75. 49.45 (52) (a) 1. of the statutes is amended to read:

49.45 **(52)** (a) 1. If the department provides the notice under par. (c) selecting the payment procedure in this paragraph, the department may, from the appropriation account under s. 20.435 (7) (b), make Medical Assistance payment adjustments to county departments under s. 46.215, 46.22, 46.23, 51.42, or 51.437 or to local health departments, as defined in s. 250.01 (4), as appropriate, for covered services under s. 49.46 (2) (a) 2. and 4. d. and f. and (b) 6. b., c., f., fm., g., j.,

k., ~~L.,~~ Lm., and m., 9., 12., 12m., 13., 15., and 16., except for services specified under s. 49.46 (2) (b) 6. b. and c. provided to children participating in the early intervention program under s. 51.44. Payment adjustments under this paragraph shall include the state share of the payments. The total of any payment adjustments under this paragraph and Medical Assistance payments made from appropriation accounts under s. 20.435 (4) (b), (gm), (o), and (w), may not exceed applicable limitations on payments under 42 USC 1396a (a) (30) (A).

SECTION 76. 49.45 (52) (b) 1. of the statutes is amended to read:

49.45 **(52)** (b) 1. Annually, a county department under s. 46.215, 46.22, 46.23, 51.42, or 51.437 shall submit a certified cost report that meets the requirements of the federal department of health and human services for covered services under s. 49.46 (2) (a) 2. and 4. d. and f. and (b) 6. b., c., f., fm., g., j., k., ~~L.,~~ Lm., and m., 9., 12., 12m., 13., 15., and 16., except for services specified under s. 49.46 (2) (b) 6. b. and c. provided to children participating in the early intervention program under s. 51.44.

SECTION 77. 49.45 (62) of the statutes is created to read:

49.45 **(62)** PRERELEASE COVERAGE OF INCARCERATED INDIVIDUALS. (a) The department may submit to the secretary of the federal department of health and human services a request for a waiver of federal Medicaid law to conduct a demonstration project to provide incarcerated individuals prerelease health care coverage for certain services under the Medical Assistance program for up to 90 days preceding the incarcerated individual's release if the individual is otherwise eligible for coverage under the Medical Assistance program.

(b) If a waiver submitted by the department under par. (a) is approved by the federal department of health and human services, the department may provide

reimbursement under the Medical Assistance program for both the federal and nonfederal share of services, including case management services, provided to incarcerated individuals under the approved waiver.

SECTION 78. 49.46 (2) (a) 3. of the statutes is amended to read:

49.46 **(2)** (a) 3. Rural health clinic services, as provided in s. 49.45 (3h).

SECTION 79. 49.46 (2) (b) 1. j. of the statutes is created to read:

49.46 **(2)** (b) 1. j. Nonsurgical treatment of temporomandibular joint disorder.

SECTION 80. 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 81. 49.46 (2) (b) 14c. of the statutes is created to read:

49.46 **(2)** (b) 14c. Subject to par. (bv), services by a psychiatric residential treatment facility.

SECTION 82. 49.46 (2) (b) 14p. of the statutes is amended to read:

49.46 **(2)** (b) 14p. Subject to s. 49.45 (30j), services provided by a peer recovery coach or a certified peer specialist.

SECTION 83. 49.46 (2) (b) 14r. of the statutes is created to read:

49.46 **(2)** (b) 14r. Detoxification and stabilization services as specified under s. 49.45 (30p).

SECTION 84. 49.46 (2) (bv) of the statutes is created to read:

49.46 **(2)** (bv) 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 services by a psychiatric residential treatment facility. If the federal department of health and

human services approves the request or if no federal approval is necessary, the department shall provide reimbursement under par. (b) 14c. If the federal department of health and human services disapproves the request, the department may not provide reimbursement for services under par. (b) 14c.

SECTION 85. 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 86. 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 87. 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 adult has a family income that does not exceed 133 percent of the poverty line, except as provided in sub. (4g).

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

SECTION 88. 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.

SECTION 89. 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 90. 49.79 (7s) of the statutes is created to read:

49.79 **(7s)** PAYMENT PROCESSING PROGRAM. The department shall administer a payment processing program to provide to farmers' markets and farmers who sell directly to consumers electronic benefit transfer and credit and debit card processing equipment and services, including electronic benefit transfer for the food stamp program. To participate in the payment processing program, the vendor that is under contract to process the electronic benefit transfer and credit and debit card transactions shall also process any local purchasing incentives, even if those local purchasing incentives are funded by a local 3rd-party entity.

SECTION 91. 49.79 (7w) (a) 1. of the statutes is amended to read:

49.79 **(7w)** (a) 1. "Eligible retailer" ~~includes any supermarket, grocery store, wholesaler, small-scale store, corner store, convenience store, neighborhood store,~~

~~bodega, farmers' market, direct-marketing farmer, nonprofit cooperative food-purchasing venture, or community-supported agriculture program~~ means a retailer authorized to participate in the ~~food stamp program~~ federal supplemental nutrition assistance program.

SECTION 92. 49.79 (7w) (b) of the statutes is amended to read:

49.79 **(7w)** (b) The department shall, through a competitive selection process, contract with one or more ~~nonprofit~~ 3rd-party organizations to administer a healthy food incentive program statewide. The healthy food incentive program shall provide to any food stamp program ~~recipient~~ assistance group that uses benefits at an eligible retailer participating in the healthy food incentive program under this subsection a monetary amount up to the amount of food stamp program benefits used at the eligible retailer for the purpose of purchasing fruits and vegetables from the eligible retailer. In administering the program, a ~~nonprofit~~ 3rd-party organization shall prioritize including in the healthy food incentive program eligible retailers that source fruits and vegetables primarily from growers in this state and shall establish a timeline for expiration of matching monetary amounts provided for the purchase of fruits and vegetables under the healthy food incentive program such that a matching monetary amount expires no later than one year after it is provided. The department may establish a maximum amount of benefits that may be matched per day for a food stamp program ~~recipient~~ assistance group. Any ~~nonprofit~~ 3rd-party organization administering the healthy food incentive program shall ensure that matching amounts provided under the program that are unused and expire remain with the ~~nonprofit~~ 3rd-party organization and, upon

expiration, are available for use to provide matching amounts to other food stamp ~~recipients~~ assistance groups under the program.

SECTION 93. 49.79 (7w) (c) of the statutes is amended to read:

49.79 **(7w)** (c) The department may allocate no more than 25 percent of the funding available for the healthy food incentive program under this subsection to program development, promotion of and outreach for the program, training, data collection, evaluation, administration, and reporting and shall allocate the remainder of the funding available to the eligible retailers participating in the healthy food incentive program under this subsection. The department shall seek, or require any 3rd-party organization chosen under par. (b) to seek, any available federal matching moneys from the Gus Schumacher Nutrition Incentive Program to fund the healthy food incentive program under this subsection.

SECTION 94. 49.79 (7w) (cd) of the statutes is created to read:

49.79 **(7w)** (cd) A 3rd-party organization chosen under par. (b) may retain for administrative purposes an amount not to exceed 33 percent of the total contracted amount or the applicable cap found in federal law or guidance, whichever is lower.

SECTION 95. 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 96. 49.79 (9) (d) of the statutes is repealed.

SECTION 97. 49.79 (9) (f) of the statutes is repealed.

SECTION 98. 49.791 of the statutes is repealed.

SECTION 99. 51.03 (7) of the statutes is created to read:

51.03 **(7)** The department shall award grants to fund services at facilities that provide crisis stabilization services, as defined in s. 51.043 (1) (b), based on criteria established by the department.

SECTION 100. 51.044 of the statutes is created to read:

51.044 Psychiatric residential treatment facilities. (1) DEFINITION. In this section, "psychiatric residential treatment facility" is a nonhospital facility that provides inpatient comprehensive mental health treatment services to individuals under the age of 21 who, due to mental illness, substance use, or severe emotional disturbance, need treatment that can most effectively be provided in a residential treatment facility.

(2) CERTIFICATION REQUIRED; EXEMPTION. (a) No person may operate a psychiatric residential treatment facility without a certification from the department. The department may limit the number of certifications it grants to operate a psychiatric residential treatment facility.

(b) A psychiatric residential treatment facility that has a certification from the department under this section is not subject to facility regulation under ch. 48.

(3) RULES. The department may promulgate rules to implement this section.

SECTION 101. 51.06 (5) of the statutes is amended to read:

51.06 **(5)** SURCHARGE FOR EXTENDED INTENSIVE TREATMENT. The department may impose on a county a progressive surcharge for services under sub. (1m) (d) that an individual receives after the maximum discharge date for the individual that was agreed upon under sub. (3) (b) 2. The surcharge is 10 percent of the amount paid for the individual's services under s. 49.45 during any part of the first 6-month period following the maximum discharge date, and increases by 10 percent of the amount paid for the individual's services under s. 49.45 during any part of each 6-month period thereafter. Any revenues received under this subsection shall be credited to the appropriation account under s. 20.435 (2) ~~(gL)~~ (g).

SECTION 102. 51.441 of the statutes is repealed.

SECTION 103. 51.442 of the statutes is repealed.

SECTION 104. 51.443 of the statutes is created to read:

51.443 Mental health consultation program. (1) In this section:

(a) "Participating clinicians" includes physicians, nurse practitioners, physician assistants, and medically appropriate members of the care teams of physicians, nurse practitioners, and physician assistants.

(b) "Program" means the mental health consultation program under this section.

(2) During fiscal year 2025-26, the department shall contract with the organization that provided consultation services through the child psychiatry consultation program under s. 51.442, 2023 stats., as of January 1, 2025, to administer the mental health consultation program described under this section. Beginning in fiscal year 2026-27, the department shall contract with the

organization that provided consultation services through the child psychiatry consultation program under s. 51.442, 2023 stats., as of January 1, 2025, or another organization to administer the mental health consultation program under this section.

(3) The contracting organization under sub. (2) shall administer a mental health consultation program that incorporates a comprehensive set of mental health consultation services, which may include perinatal, child, adult, geriatric, pain, veteran, and general mental health consultation services, and may contract with any other entity to perform any operations and satisfy any requirements under this section for the program.

(4) As a condition of providing services through the program, the contracting organization under sub. (2) shall do all of the following:

(a) Ensure that all mental health care providers who are providing services through the program have the applicable credential from this state; if a psychiatric professional, that the provider is eligible for certification or is certified by the American Board of Psychiatry and Neurology for adult psychiatry, child and adolescent psychiatry, or both; and if a psychologist, that the provider is registered in a professional organization, including the American Psychological Association, National Register of Health Service Psychologists, Association for Psychological Science, or the National Alliance of Professional Psychology Providers.

(b) Maintain the infrastructure necessary to provide the program's services statewide.

(c) Operate the program on weekdays during normal business hours of 8 a.m. to 5 p.m.

(d) Provide consultation services under the program as promptly as is practicable.

(e) Have the capability to provide consultation services by, at a minimum, telephone and email. Consultation through the program may be provided by teleconference, video conference, voice over Internet protocol, email, pager, in-person conference, or any other telecommunication or electronic means.

(f) Provide all of the following services through the program:

1. Support for participating clinicians to assist in the management of mental health concerns.

2. Triage-level assessments to determine the most appropriate response to each request, including appropriate referrals to any community providers and health systems.

3. When medically appropriate, diagnostics and therapeutic feedback.

4. Recruitment of other clinicians into the program as participating clinicians when possible.

(g) Report to the department any information requested by the department.

(h) Conduct annual surveys of participating clinicians who use the program to assess the quality of care provided, self-perceived levels of confidence in providing mental health services, and satisfaction with the consultations and other services provided through the program. Immediately after participating clinicians begin using the program and again 6 to 12 months later, the contracting organization

under sub. (2) may conduct assessments of participating clinicians to assess the barriers to and benefits of participation in the program to make future improvements and to determine the participating clinicians' treatment abilities, confidence, and awareness of relevant resources before and after beginning to use the program.

(5) Services provided under sub. (4) (b) to (h) are eligible for funding from the department. The contracting organization under sub. (2) also may provide any of the following services under the program that are eligible for funding from the department:

(a) Second opinion diagnostic and medication management evaluations and community resource referrals conducted by either a psychiatrist or allied health professionals.

(b) In-person or web-based educational seminars and refresher courses on a medically appropriate topic within mental or behavioral health care provided to any participating clinician who uses the program.

(c) Data evaluation and assessment of the program.

SECTION 105. 69.186 (1) (hf) of the statutes is amended to read:

69.186 **(1)** (hf) The probable ~~postfertilization age of the unborn child, as defined in s. 253.107 (1) (c), and whether an ultrasound was used to assist in making the determination of postfertilization age of the unborn child,~~ gestational age of the pregnancy or, if the probable ~~postfertilization age of the unborn child~~ gestational age of the pregnancy was not determined, the nature of the medical emergency, as defined in s. ~~253.10 (2) (d)~~ 253.107 (1) (b).

SECTION 106. 69.186 (1) (k) of the statutes is amended to read:

69.186 **(1)** (k) If the unborn child is considered to be capable of experiencing pain under s. 253.107 (3) (a), the nature of the medical emergency, as defined in s. ~~253.10 (2) (d)~~ 253.107 (1) (b), that the pregnant woman had.

SECTION 107. 71.03 (9) of the statutes is created to read:

71.03 **(9)** MEDICAL ASSISTANCE COVERAGE. (a) The department shall include the following questions and explanatory information on each individual income tax return under this section and a method for the taxpayer to respond to each question:

1. "Are you, your spouse, your dependent children, or any eligible adult child dependent not covered under a health insurance policy, health plan, or other health care coverage? 'Eligible adult child dependent' means a child who is under the age of 26 who is a full-time student or a child who is under the age of 27 who is called to active duty in the national guard or armed forces reserve while enrolled as a full-time student."

2. "If you responded 'yes' to question 1, do you want to have evaluated your eligibility for Medical Assistance under subch. IV of ch. 49 of the Wisconsin Statutes or your eligibility for subsidized health insurance coverage?"

(b) For each person who responded "yes" to the question under par. (a) 2., the department shall provide that person's contact information and other relevant information from that person's individual income tax return to the department of health services to perform an evaluation of that person's eligibility under the Medical Assistance program under subch. IV of ch. 49 or an evaluation of that person's eligibility for subsidized health insurance coverage through an exchange, as defined under 45 CFR 155.20. The information provided to the department of

health services may not be used to determine that the individual is ineligible to enroll in the Medical Assistance program under subch. IV of ch. 49.

SECTION 108. 71.78 (4) (w) of the statutes is created to read:

71.78 **(4)** (w) The secretary of health services and employees of the department of health services for the purpose of performing an evaluation under s. 71.03 (9) (b).

SECTION 109. 77.51 (9rm) of the statutes is created to read:

77.51 **(9rm)** "Over-the-counter-drug" means a drug that contains a label that identifies the product as a drug as required by 21 CFR 201.66, including a label that includes any of the following:

(a) A drug facts panel.

(b) A statement of the active ingredients with a list of those ingredients contained in the compound, substance, or preparation.

SECTION 110. 77.54 (14) (g) of the statutes is created to read:

77.54 **(14)** (g) Over-the-counter-drugs.

SECTION 111. 146.615 (title) of the statutes is amended to read:

146.615 (title) ~~**Advanced practice clinician**~~ **Health care provider training grants.**

SECTION 112. 146.615 (1) (ag) and (ar) of the statutes are created to read:

146.615 **(1)** (ag) "Allied health professional" means any individual who is a health care provider other than a physician, dentist, pharmacist, chiropractor, or podiatrist and who provides diagnostic, technical, therapeutic, or direct patient care and support services to a patient.

(ar) "Behavioral health provider" means any individual who is licensed as a

psychologist or is certified as a social worker or licensed as a clinical social worker, a marriage and family therapist, or a professional counselor.

SECTION 113. 146.615 (2) of the statutes is amended to read:

146.615 **(2)** Beginning in fiscal year ~~2018-19~~ 2025-26, from the appropriation under s. 20.435 (1) (fk), subject to sub. (3), the department shall distribute grants to hospitals, health systems, and clinics that provide new training opportunities for advanced practice clinicians. The department shall distribute the grants under this ~~section~~ subsection to hospitals, health systems, and clinics that apply, in the form and manner determined by the department, to receive grants ~~and that satisfy the criteria under sub. (3)~~.

SECTION 114. 146.615 (2g) and (2r) of the statutes are created to read:

146.615 **(2g)** Beginning in fiscal year 2025-26, from the appropriation under s. 20.435 (1) (fk), subject to sub. (3), the department shall distribute grants to hospitals, health systems, clinics, and educational entities that form health care education and training consortia for allied health professionals. The department shall distribute the grants under this subsection to hospitals, health systems, clinics, and educational entities that apply, in the form and manner determined by the department, to receive a grant.

(2r) Beginning in fiscal year 2025-26, from the appropriation under s. 20.435 (1) (fk), subject to sub. (3), the department shall distribute grants to hospitals, health systems, clinics, and educational entities that form health care education and training consortia for behavioral health providers. The department shall distribute the grants under this subsection to hospitals, health systems, clinics, and

educational entities that apply, in the form and manner determined by the department, to receive a grant.

SECTION 115. 146.615 (3) (a) of the statutes is repealed.

SECTION 116. 146.615 (3) (b) of the statutes is amended to read:

146.615 **(3)** (b) ~~If the department distributes a grant to a hospital or clinic that has not previously received a grant under this section, the hospital or clinic receiving the grant may use the grant to create the education and infrastructure for training advanced practice clinicians or for activities authorized under par. (c).~~ In distributing grants under this section, the department shall give preference to ~~advanced practice clinician clinical~~ training programs that include rural hospitals and rural clinics as clinical training locations.

SECTION 117. 146.615 (3) (bm) of the statutes is created to read:

146.615 **(3)** (bm) Acceptable uses of grant moneys received under this section include reasonable expenses incurred by a trainee to fully succeed in training and eventual placement, expenses related to planning and implementing a training program, and up to $5,000 in equipment expenses.

SECTION 118. 146.615 (3) (c) and (d) of the statutes are repealed.

SECTION 119. 146.616 of the statutes is repealed.

SECTION 120. 146.691 of the statutes is created to read:

146.691 Reporting of medical debt to a consumer reporting agency.

(1) In this section:

(a) "Consumer reporting agency" has the meaning given in s. 100.54 (1) (c).

(b) "Health care provider" has the meaning given in s. 146.81 (1).

(c) "Patient" has the meaning given in s. 146.81 (3).

(2) No health care provider that provided services to a patient, and no billing administrator or debt collector acting on behalf of that health care provider, may report to a consumer reporting agency that a debt arising from services provided by the health care provider is in collections status unless all of the following are true:

(a) The health care provider, billing administrator, or debt collector sent a written statement to the patient describing the unpaid amount and due date and that included the name and address of the health care provider that provided the services.

(b) The written statement under par. (a) includes a statement indicating that if payment is not received, the debt may be reported to a credit reporting agency.

(c) Six months have passed since the due date listed on the statement under par. (a).

(d) The patient does not dispute the charges.

SECTION 121. 146.82 (2) (a) 8m. of the statutes is created to read:

146.82 **(2)** (a) 8m. To the Population Health Institute, or its successor, at the University of Wisconsin-Madison School of Medicine and Public Health under s. 255.18 (2) and to the persons specified under s. 36.47 (3) (f). The release of a patient health care record under this subdivision shall be limited to the information specified in the list under s. 36.47 (3) (d).

SECTION 122. 150.31 (1) (intro.) of the statutes is amended to read:

150.31 **(1)** (intro.) In order to enable the state to budget accurately for medical assistance and to allocate fiscal resources most appropriately, the maximum number of licensed nursing home beds statewide is ~~51,795~~ 25,415 and the maximum number of beds statewide in facilities primarily serving the

developmentally disabled is 3,704. The department may adjust these limits on licensed beds as provided in subs. (2) to (6). The department shall also biennially recommend changes to this limit based on the following criteria:

SECTION 123. 150.31 (8) of the statutes is amended to read:

150.31 **(8)** ~~The~~ Subject to sub. (9), the department may allocate or distribute nursing home beds in a manner, developed by rule, that is consistent with the criteria specified in sub. (1) (a) to (f) and s. 150.39.

SECTION 124. 150.31 (9) of the statutes is created to read:

150.31 **(9)** The department shall allocate 125 nursing home beds to persons that apply for the beds and agree to do all of the following:

(a) Prioritize admissions of patients with complex needs.

(b) Prioritize admissions of patients who have been unable to find appropriate placement at another facility.

SECTION 125. Subchapter IX of chapter 150 [precedes 150.99] of the statutes is created to read:

CHAPTER 150

SUBCHAPTER IX

HEALTH CARE ENTITY OVERSIGHT AND TRANSPARENCY

SECTION 126. 150.99 of the statutes is created to read:

150.99 Definitions. In this subchapter:

(1) "Acquisition" means the direct or indirect purchase, including lease, transfer, exchange, option, receipt of a conveyance, or creation of a joint venture, or any other manner of purchase, such as by a health care system, private equity group, hedge fund, publicly traded company, real estate investment trust,

management services organization, insurance carrier, or any subsidiaries thereof, of a material amount of the assets or operations of a health care entity.

(2) "Affiliate" means any of the following:

(a) A person, entity, or organization that directly, indirectly, or through one or more intermediaries controls, is controlled by, or is under common control or ownership of another person, entity, or organization.

(b) A person whose business is operated under a lease, management, or operating agreement by another entity, or a person substantially all of whose property is operated under a management or operating agreement with that other entity.

(c) An entity that operates the business or substantially all the property of another entity under a lease, management, or operating agreement.

(d) Any out-of-state operations and corporate affiliates of an affiliate as defined in pars. (a) to (c), including significant equity investors, health care real estate investment trusts, or management services organizations.

(3) "Arrangement" includes any agreement, association, partnership, joint venture, management services agreement, professional services agreement, health care staffing company agreement, or other arrangement that results in a change of governance or control of a health care entity or a department, subdivision, or subsidiary of a health care entity.

(4) "Change of control" means an arrangement in which any person, corporation, partnership, or any entity acquires direct or indirect control over the operations of a health care entity in whole or in substantial part.

(5) "Control," "controlling," "controlled by," and "under common control

with" means the direct or indirect power through ownership, contractual agreement, or otherwise to do any of the following:

(a) Vote 10 percent or more of any class of voting shares or interests of a health care entity.

(b) Direct the actions or policies of the specified entity.

(6) "Health care facility" means an institution that provides health care services or a health care setting, including hospitals and other inpatient facilities, health systems consisting of one or more health care entities that are jointly owned or managed, ambulatory surgical or treatment centers, skilled nursing facilities, residential treatment centers, diagnostic, laboratory, and imaging centers, freestanding emergency facilities, outpatient clinics, and rehabilitation and other therapeutic health settings.

(7) "Health care provider" means any person, corporation, partnership, governmental unit, state institution, medical practice, or other entity that performs or provides health care services to persons in the state.

(8) "Health care services" means services and payments for the care, prevention, diagnosis, treatment, cure, or relief of a medical, dental, or behavioral health condition, illness, injury, or disease, including any of the following:

(a) Inpatient, outpatient, habilitative, rehabilitative, dental, palliative, therapeutic, supportive, home health, or behavioral services provided by a health care entity.

(b) Pharmacy, retail, and specialty, including any drug, device, or medical supply.

(c) Performance of functions to refer, arrange, or coordinate care.

(d) Equipment used such as durable medical equipment, diagnostic, surgical devices, or infusion.

(e) Technology associated with the provision of services or equipment in pars. (a) to (d) above, such as telehealth, electronic health records, software, claims processing, or utilization systems.

(9) "Health care staffing company" means a person, firm, corporation, partnership, or other business entity engaged in the business of providing or procuring, for temporary employment or contracting by a health care facility, any health care personnel, but does not include an individual who independently provides the individual's own services on a temporary basis to health care facilities as an employee or contractor.

(10) "Licensee" means an individual who is licensed in the state as a physician, a doctor of osteopathy, or a physician assistant or a nurse practitioner who is authorized to diagnose and treat in the applicable clinical setting.

(11) "Management services organization" means any organization or entity that contracts with a health care provider or provider organization to perform management or administrative services relating to, supporting, or facilitating the provision of health care services.

(12) "Medical practice" means a corporate entity or partnership organized for the purpose of practicing medicine and permitted to practice medicine in the state, including partnerships, professional corporations, limited liability companies, and limited liability partnerships.

(13) "Noncompetition agreement" means a written agreement between a licensee and another person under which the licensee agrees that the licensee,

either alone or as an employee, associate, or affiliate of a third person, will not compete with the other person in providing products, processes, or services that are similar to the other person's products, processes, or services for a period of time or within a specified geographic area after termination of employment or termination of a contract under which the licensee supplied goods to or performed services for the other person.

(14) "Nondisclosure agreement" means a written agreement under the terms of which a licensee must refrain from disclosing partially, fully, directly, or indirectly to any person, other than another party to the written agreement or to a person specified in the agreement as a 3rd-party beneficiary of the agreement, any of the following:

(a) A policy or practice that a party to the agreement required the licensee to use in patient care, other than individually identifiable health information that the licensee may not disclose under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, in effect on the effective date of this paragraph .... [LRB inserts date].

(b) A policy, practice, or other information about or associated with the licensee's employment, conditions of employment, or rate or amount of pay or other compensation.

(c) Any other information the licensee possesses or to which the licensee has access by reason of the licensee's employment by, or provision of services for or on behalf of, a party to the agreement, other than information that is subject to protection under applicable law as a trade secret of, or as otherwise proprietary to,

another party to the agreement or to a person specified in the agreement as a third-party beneficiary of the agreement.

(15) "Nondisparagement agreement" means a written agreement under which a licensee must refrain from making to a 3rd party a statement about another party to the agreement or about another person specified in the agreement as a 3rd-party beneficiary of the agreement, the effect of which causes or threatens to cause harm to the other party's or person's reputation, business relations, or other economic interests.

(16) "Ownership or investment interest" means any of the following:

(a) Direct or indirect possession of equity in the capital, stock, or profits totaling more than 5 percent of an entity.

(b) Interest held by an investor or group of investors who engages in the raising or returning of capital and who invests, develops, or disposes of specified assets.

(c) Interest held by a pool of funds by investors, including a pool of funds managed or controlled by private limited partnerships, if those investors or the management of that pool or private limited partnership employ investment strategies of any kind to earn a return on that pool of funds.

(17) "Private equity fund" means a publicly traded or nonpublicly traded company that collects capital investments from individuals or entities and purchases a direct or indirect ownership share or controlling interest of a health care entity.

(18) "Provider organization" means any corporation, partnership, business trust, association, or organized group of persons that is in the business of health

care delivery or management, whether incorporated or not, that represents one or more health care providers in contracting with insurance carriers for the payments of health care services. "Provider organization" includes physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations, management services organizations, and any other organization that contracts with insurance carriers for payment for health care services.

(19) "Significant equity investor" means any of the following:

(a) Any private equity fund with a direct or indirect ownership or investment interest in a health care entity.

(b) Any investor, group of investors, or other entity with a direct or indirect possession of equity in the capital, stock, or profits totaling more than 10 percent of a health care provider or provider organization.

(c) Any private equity fund, investor, group of investors, or other entity with a direct or indirect controlling interest in a health care entity or that operates the business or substantially all of the property of a health care entity under a lease, management, or operating agreement.

SECTION 127. 150.992 of the statutes is created to read:

150.992 Material change transactions. (1) NOTICE. (a) Any health care entity shall, before consummating any material change transaction, submit written notice to the department not fewer than 180 days before the date of the proposed material change transaction. The department shall promulgate rules to define, for purposes of this subchapter, what entities are considered health care entities and what constitutes a material change transaction.

(b) Written notice shall include and contain the information the department determines is required. The health care entity may include any additional information supporting the written notice of the material change transaction. Notice is complete when the department determines that all required information has been received.

(c) All information provided by the submitter as part of the notice shall be treated as public record unless the submitter designates documents or information as confidential when submitting the notice and the department concurs with the designation in accordance with a process specified by the department by rule. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall be considered public. The department shall maintain the confidentiality of all confidential information obtained in relation to a material change transaction, except that the department may share confidential information with other appropriate state agencies and departments to carry out their respective authorities under this section and may disclose any information to an expert or consultant under contract with the department, provided that the expert or consultant is bound by the same confidentiality requirements as the department. The confidential information and documents may not be treated as public records and are not subject to inspection or copying under s. 19.35.

(d) The department shall post on its publicly available website information about the material change transaction no less than 30 days before the anticipated implementation of the material change transaction or, if the department is notified less than 30 days before the anticipated implementation, as soon as is practicable. The department shall include in the information posted on its website under this

paragraph at least all of the following information regarding the material change transaction:

1. A summary of the proposed transaction, including the identity of the parties to the transaction.

2. A description of the groups or individuals likely to be affected by the transaction.

3. Information about services currently provided by the health care entity, commitments by the health care entity to continue such services, and any services that will be reduced or eliminated.

4. Details about any public hearings and how to submit comments.

5. Any other information from the notice and other materials submitted by the health care entity that the attorney general or the department determines would be in the public interest, except for materials designated confidential under par. (c).

(e) For purposes of calculating time periods under this section, notice shall be considered received on the first business day after the department determines that notice is complete.

(2) PRELIMINARY REVIEW. (a) Within 30 days after receiving notice as described in sub. (1), the department shall do one of the following:

1. Approve the material change transaction and notify the health care entity in writing that a comprehensive review is not required for the material change transaction.

2. Approve the material change transaction subject to conditions set by the department and notify the health care entity in writing of the conditions under which the transaction may be completed.

3. Notify the health care entity in writing that the transaction is subject to a comprehensive review. The department may request additional information necessary to perform a comprehensive review under sub. (3).

(b) Nothing in this section limits or infringes upon the existing authority of any state agency or the attorney general to review any transactions.

(3) COMPREHENSIVE REVIEW PROCESS. (a) For purposes of this subsection, "market power" means possessing 30 percent or more market share in any line of service in the relevant geographic area or meeting other criteria that the department may define by rule.

(b) A comprehensive review is required when any of the following apply to the material change transaction:

1. The transaction will result in the transfer of assets valued above $20 million.

2. The transaction occurs in a highly consolidated market for any line of services offered by any party to the material change transaction.

3. The transaction will cause a significant change in market share such that any resulting health care entity possesses market power upon completion.

4. The transaction will otherwise reduce competition, including effects of vertical or cross-market transactions among different product or geographic markets.

5. Either party to the material change transaction possesses market power prior to the transaction.

6. The department, at its sole discretion, determines that the material change

transaction is likely to have a material impact on the cost of, quality of, equity of, or access to health care services in any region in the state.

(c) No later than 90 days after determining a material change transaction is subject to a comprehensive review, the department shall conduct the review and shall conduct one or more public hearings or public meetings, one of which shall be in the county in which the health care entity is located, to hear comments from interested parties.

(d) Not more than 90 days after determining that the material change transaction is subject to a comprehensive review under this subsection, the department shall produce a cost and market impact review report containing the findings and conclusions of the cost and market impact review, provided that the health care entity has complied with the requests for information or documents pursuant to this subsection within 21 days of the request or by a later date set by mutual agreement of the health care entity and the department. The cost and market impact review report shall be posted publicly and may not disclose confidential information.

(e) The cost and market impact review may examine factors relating to the proposed material change transaction, transacting parties, and their relative market position, including any of the following:

1. The market share of each transacting party and the likely effects of the material change transaction on competition.

2. Any previous material change transaction involving any transacting party, including acquisitions or mergers of similar health care providers, whether or not in the same state.

3. The prices charged by each transacting party for services, including their relative prices compared to others' prices for the same services in the same geographic area.

4. The quality of the services provided by any health care provider party to the material change transaction, including patient experience.

5. The cost and cost trends of any health care entity party in comparison to total health care expenditures statewide.

6. The availability and accessibility of services similar to those provided, or proposed to be provided, through any health care provider or provider organization party within its primary service areas and dispersed service areas.

7. The impact of the material change transaction on competing options for the delivery of health care services within the primary service areas and dispersed service areas of the transacting parties.

8. The role of the transacting parties in serving at-risk, underserved, and government-payer patient populations.

9. The role of the transacting parties in providing low-margin or negative-margin services within its primary service areas and dispersed service areas.

10. Consumer concerns, including complaints or other allegations that any provider or provider organization party has engaged in any unfair method of competition or any unfair or deceptive act or practice.

11. The parties' compliance with prior conditions and legal requirements related to competitive conduct, including compliance with s. 150.994, reporting requirements regarding health care entity ownership and control under s. 150.996, or restrictions on anticompetitive contracting provisions.

12. The impact of the material change transaction on the clinical workforce, including wages, staffing levels, supply, patient access, and continuity of patient-care relationships.

13. The impact of a real estate sale or lease agreement on the financial condition of any health care entity party and its ability to maintain patient care operations.

14. In the case of a proposed closure or discontinuance of a health care facility or any essential health services, the impact of the closure on health care access, outcomes, costs, and equity for those in the health care facility's service area and the health care facility's plan for ensuring equitable access, quality, affordability, and availability of essential health services within the service area.

15. Any other factors that the department determines, by rules promulgated by the department, to be in the public interest.

(f) The department may request additional information or documents from the transacting parties necessary to conduct a cost and market impact review. Failure to respond or insufficient responses to requests for information by transacting parties may result in the extension of the deadline for the department to complete the cost and market impact review, the imposition of conditions for approval, or the disapproval of the material change transaction.

(g) The department shall keep confidential all nonpublic information and documents obtained under this subsection and may not disclose the confidential information or documents to any person without the consent of the party that produced the confidential information or documents, except that the department may disclose any information to an expert or consultant under contract with the

department to review the proposed transaction, provided that the expert or consultant is bound by the same confidentiality requirements as the department. The confidential information and documents and work product of the department may not be treated as public records and shall be exempt from inspection or copying under s. 19.35.

(h) The department may, in its sole discretion:

1. Contract with, consult, and receive advice from any state agency on those terms and conditions that the department determines are appropriate with regard to reviewing a proposed material change transaction.

2. Contract with experts or consultants to assist in reviewing a proposed material change transaction.

(i) The department shall be entitled to charge costs to or receive reimbursement from the transacting parties for all actual, reasonable, direct costs incurred in reviewing, evaluating, and making the determination referred to in this subsection, including administrative costs and costs of contracted experts or consultants in par. (h).

(4) APPROVAL AUTHORITY. (a) The department may at its discretion approve, conditionally approve, or disapprove of any material change transaction for which the department receives notice under sub. (1). Any conditions imposed under this subsection shall specify a time period for compliance, an expiration date, or that the condition applies indefinitely.

(b) The department shall inform the health care entity of the determination within 30 days of notice under sub. (2), or in the case of comprehensive review, within 60 days of the completion of the cost and market impact review. No proposed

material change transaction may be completed before the department has informed the health care entity of the determination.

(c) In making the determination under this subsection, the department may consider any factors that the department determines to be relevant, including any of the following:

1. The likely impact, as described in the cost and market impact review report, where applicable, of the material change transaction on any of the following:

a. Health care costs, prices, and affordability.

b. The availability or accessibility of health care services to the affected community.

c. Health care provider cost trends and containment of total state health care spending.

d. Access to services in medically underserved areas.

e. Rectifying historical and contemporary factors contributing to a lack of health equities or access to services.

f. The functioning and competitiveness of the markets for health care and health insurance.

g. The potential effects of the material change transaction on health outcomes, quality, access, equity, or workforce for residents of this state.

h. The potential loss of or change in access to essential services.

2. Whether the material change transaction is contrary to or violates any applicable law, including state antitrust laws, laws restricting the corporate practice of medicine, or consumer protection laws.

3. Whether the benefits of the transaction are likely to outweigh any anticompetitive effect from the transaction.

4. Whether the transaction is in the public interest.

(d) This subsection does not limit or alter any existing authority of the attorney general or any state agency to enforce any other law, including state or federal antitrust law, or to review nonprofit transactions.

(5) POST-TRANSACTION OVERSIGHT. (a) *Enforcement by the attorney general.* 1. The attorney general may subpoena any records necessary to enforce any provisions of this section or to investigate suspected violations of any provisions of this section or any conditions imposed by conditional approval pursuant to sub. (4).

2. The attorney general may enforce any requirement of this section and any conditions imposed by a conditional approval pursuant to sub. (4) to the fullest extent provided by law, including damages. In addition to any legal remedies the attorney general may have, the attorney general shall be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for any violations or imminent violation of any requirement of this section or breach of any of the conditions and shall be entitled to recover its attorney fees and costs incurred in remedying each violation.

3. In addition to the remedies set forth in subd. 2., any person who violates this section or of any conditions imposed pursuant to a conditional approval under sub. (4) is subject to a forfeiture of $10,000 per day, which the attorney general may seek to recover by action on behalf of the state. The attorney general may also rescind or deny approval for any other past, pending, or future material change transactions involving the health care entity or an affiliate.

4. Nothing in this paragraph shall narrow, abrogate, or otherwise alter the authority of the attorney general to prosecute violations of antitrust or consumer protection requirements.

(b) *Enforcement by the department.* 1. The department may audit the books, documents, records, and data of any entity that is subject to a conditional approval under sub. (4) to monitor compliance with the conditions.

2. Any entity that violates any provision of this section, any rules adopted pursuant thereto, or any condition imposed pursuant to a conditional approval under sub. (4) shall be subject to a forfeiture of $10,000 per day for any violation of this section.

3. The department may refer any entity to the attorney general to review for enforcement of any noncompliance with this section and any conditions imposed by conditional approval pursuant to sub. (4).

(c) *Monitoring.* In order to effectively monitor ongoing compliance with the terms and conditions of any material change transaction subject to prior notice, approval, or conditional approval under sub. (4), the department may, in its sole discretion, conduct a review or audit and may contract with experts and consultants to assist in this regard.

(d) *Reporting.* One year, 2 years, and 5 years following the completion of the material change transaction approved or conditionally approved by the department after a comprehensive review under sub. (3), and upon future intervals determined at the discretion of the department, the health care entity or any person, corporation, partnership, or other entity that acquired direct or indirect control over

the health care entity shall submit reports to the department that do all of the following:

1. Demonstrate compliance with conditions placed on the material change transaction, if any.

2. Analyze cost trends and cost growth trends of the transacting parties.

3. Analyze any changes or effects of the material change transaction on patient access, availability of services, workforce, quality, or equity.

(e) *Costs.* The department shall be entitled to charge costs to the transacting parties for all actual, reasonable, and direct costs incurred in monitoring ongoing compliance with the terms and conditions of the sale or transfer of assets, including contractor and administrative costs.

(6) RULES. The department may promulgate rules to implement this section.

SECTION 128. 150.994 of the statutes is created to read:

150.994 Corporate practice of medicine. The corporate practice of medicine is prohibited. The department shall promulgate rules to define what conduct constitutes the corporate practice of medicine for purposes of this section.

SECTION 129. 150.996 of the statutes is created to read:

150.996 Transparency in ownership and control of health care entities. (1) REPORTING OF OWNERSHIP AND CONTROL. Each health care entity shall report to the department on an annual basis and upon the consummation of a material change transaction involving the entity as set forth in s. 150.992, in a form and manner required by the department, all of the following information, as applicable:

(a) Legal name of entity.

(b) Business address of entity.

(c) Locations of operations.

(d) Business identification numbers of the entity, as applicable, including all of the following:

1. Taxpayer identification number.

2. National provider identifier.

3. Employer identification number.

4. Centers for Medicare and Medicaid Services certification number.

5. National Association of Insurance Commissioners identification number.

6. A personal identification number associated with a license issued by the commissioner of insurance.

7. Pharmacy benefit manager identification number associated with a license or registration of the pharmacy benefit manager in this state.

(e) Name and contact information of a representative of the entity.

(f) The name, business address, and business identification numbers listed in par. (d) for each person or entity that, with respect to the relevant health care entity, has an ownership or investment interest, has a controlling interest, is a management services organization, or is a significant equity investor.

(g) A current organizational chart showing the business structure of the health care entity, including all of the following:

1. Any entity listed in par. (f).

2. Affiliates, including entities that control or are under common control as the health care entity.

3. Subsidiaries.

(h) For a health care entity that is a provider organization or a health care facility, all of the following information:

1. a. The affiliated health care providers identified by name, license type, specialty, national provider identifier, and other applicable identification number listed in par. (d).

b. The address of the principal practice location.

c. Whether the health care provider is employed or contracted by the entity.

2. The name and address of affiliated health care facilities by license number, license type, and capacity in each major service area.

(i) The names, national provider identifier, if applicable, and compensation of all of the following:

a. The members of the governing board, board of directors, or similar governance body for the health care entity.

b. Any entity that is owned or controlled by, affiliated with, or under common control as the health care entity.

c. Any entity listed in par. (f).

(j) Comprehensive financial reports of the health care entity and any ownership or control entities, including audited financial statements, cost reports, annual costs, annual receipts, realized capital gains and losses, accumulated surplus, and accumulated reserves.

(2) EXCEPTIONS. All of the following health care entities are exempt from the reporting requirements under sub. (1):

(a) A health care entity that is an independent provider organization, without any ownership or control entities, consisting of 2 or fewer physicians, provided that

if that health care entity experiences a material change transaction under s. 150.992, the health care entity is subject to reporting under sub. (1) upon the consummation of the transaction.

(b) A health care provider or provider organization that is owned or controlled by another health care entity, if the health care provider or provider organization is shown in the organizational chart submitted under sub. (1) (g) and the owning or controlling health care entity reports all the information required under sub. (1) on behalf of the controlled or owned entity. Health care facilities are not subject to this exception.

(3) RULES. (a) The department shall promulgate any rules necessary to implement this section, specify the format and content of reports, and impose penalties for noncompliance. The department may require additional reporting of data or information that it determines is necessary to better protect the public's interest in monitoring the financial conditions, organizational structure, business practices, and market share of each registered health care entity.

(b) The department may assess administrative fees on health care entities in an amount to help defray the costs in overseeing and implementing this section.

(4) OWNERSHIP INFORMATION. (a) Information provided under this section shall be public information and may not be considered confidential, proprietary, or a trade secret, except that any individual health care provider's taxpayer identification that is also their social security number shall be confidential.

(b) Not later than December 31, 2028, and annually thereafter, the department shall post on its publicly available website a report with respect to the previous one-year period, including all of the following information:

1. The number of health care entities reporting for the year, disaggregated by the business structure of each specified entity.

2. The names, addresses, and business structure of any entities with an ownership or controlling interest in each health care entity.

3. Any change in ownership or control for each health care entity.

4. Any change in the tax identification number of a health care entity.

5. As applicable, the name, address, tax identification number, and business structure of other affiliates under common control, subsidiaries, and management services entities for the health care entity, including the business type and the tax identification number of each.

6. An analysis of trends in horizontal and vertical consolidation, disaggregated by business structure and provider type.

(c) The department may share information reported under this section with the attorney general, other state agencies, and other state officials to reduce or avoid duplication in reporting requirements or to facilitate oversight or enforcement under state law. Any tax identification numbers that are individual social security numbers may be shared with the attorney general, other state agencies, or other state officials that agree to maintain the confidentiality of such information. The department may, in consultation with the relevant state agencies, merge similar reporting requirements where appropriate.

(5) ENFORCEMENT. (a) *Audit and inspection authority.* The department is authorized to audit and inspect the records of any health care entity that has failed to submit complete information pursuant to this section or if the department has

reason to question the accuracy or completeness of the information submitted pursuant this section.

(b) *Random audits.* The department shall conduct annual audits of a random sample of health care entities to verify compliance with, accuracy, and completeness of the reported information pursuant to this section.

(c) *Penalty for failure to report.* If a health care entity fails to provide a complete report under sub. (1), or submits a report containing false information, the entity shall be subject to all of the following civil penalties, as appropriate:

1. Health care entities consisting of independent health care providers or provider organizations without any 3rd-party ownership or control entities, with 10 or fewer physicians or less than $10 million in annual revenue, a forfeiture of up to $50,000 for each report not provided or containing false information.

2. For all other health care entities, a forfeiture of up to $500,000 for each report not provided or containing false information.

SECTION 130. 250.15 (1) (b) 7. of the statutes is created to read:

250.15 **(1)** (b) 7. The organizations are not health center look-alikes.

SECTION 131. 250.15 (1) (c) of the statutes is created to read:

250.15 **(1)** (c) "Health center look-alike" means a health care entity that is designated by the federal health resources and services administration as a federally qualified health center look-alike.

SECTION 132. 250.15 (2) (d) of the statutes is amended to read:

250.15 **(2)** (d) ~~Two million two hundred fifty thousand dollars to~~ To free and charitable clinics, $2,500,000.

SECTION 133. 250.15 (2) (e) of the statutes is created to read:

250.15 **(2)** (e) To health center look-alikes, $200,000. A grant awarded to a health center look-alike under this paragraph may not exceed $100,000.

SECTION 134. 252.12 (2) (a) 8. (intro.) of the statutes is amended to read:

252.12 **(2)** (a) 8. 'Mike Johnson life care and early intervention services grants.' (intro.) The department shall award not more than ~~$4,000,000~~ $4,500,000 in each fiscal year in grants to applying AIDS service organizations for the provision of needs assessments; assistance in procuring financial, medical, legal, social and pastoral services; counseling and therapy; homecare services and supplies; advocacy; and case management services. These services shall include early intervention services. The department shall also award not more than $74,000 in each year from the appropriation account under s. 20.435 (5) (md) for the services under this subdivision. The state share of payment for case management services that are provided under s. 49.45 (25) (be) to recipients of medical assistance shall be paid from the appropriation account under s. 20.435 (1) (am). All of the following apply to grants awarded under this subdivision:

SECTION 135. 253.07 (1) (a) 3. of the statutes is created to read:

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

SECTION 136. 253.07 (1) (b) 3. of the statutes is created to read:

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

SECTION 137. 253.07 (5) (b) (intro.) of the statutes is renumbered 253.07 (5) (b) and amended to read:

253.07 **(5)** (b) ~~Subject to par. (c), a~~ A public entity that receives women's health funds under this section may provide some or all of the funds to other public

or private entities ~~provided that the recipient of the funds does not do any of the following:~~.

SECTION 138. 253.07 (5) (b) 1. to 3. of the statutes are repealed.

SECTION 139. 253.07 (5) (c) of the statutes is repealed.

SECTION 140. 253.094 of the statutes is created to read:

253.094 Right to abortion. (1) Every individual has the fundamental right to bodily autonomy, which includes the right to access abortion. The state may not prohibit an individual from obtaining an abortion at any time during the pregnancy if an abortion is necessary in the professional judgment of the individual's medical provider.

(2) (a) Except as provided in sub. (1), a law or rule of this state that restricts an individual's access to abortion is unenforceable if the law or rule does not confer any legitimate health benefit, such as by expanding an individual's access to health care services or by, according to evidence-based research, increasing the individual's safety.

(b) Any person that is or may be aggrieved by the enforcement of a law or rule passed or promulgated after the effective date of this paragraph .... [LRB inserts date], that violates this subsection may bring an action in state or federal court for injunctive relief or damages against a state or local official who enforces or attempts to enforce such a law or rule.

SECTION 141. 253.095 of the statutes is repealed.

SECTION 142. 253.10 of the statutes is repealed and recreated to read:

253.10 Requirements for providers of abortion care. (1) All

requirements applicable to health care providers are applicable to providers of abortion care.

SECTION 143. 253.105 of the statutes is repealed.

SECTION 144. 253.107 (1) (b) of the statutes is amended to read:

253.107 **(1)** (b) "Medical emergency" ~~has the meaning given in s. 253.10 (2) (d)~~ means a condition, in a physician's reasonable medical judgment, that makes an abortion necessary.

SECTION 145. 253.13 (6) of the statutes is created to read:

253.13 **(6)** FEDERAL RECOMMENDATIONS; EVALUATION PROCEDURE. (a) *Initial evaluation.* 1. Subject to subd. 2., for any disorder that is added to the federal recommended uniform screening panel approved by the federal department of health and human services after January 1, 2025, and that is not included in the list of disorders under s. DHS 115.04, Wis. Adm. Code, the department shall do all of the following within 18 months after the addition of the disorder:

a. Conduct an initial evaluation to determine whether the disorder should be included in the testing required under this section.

b. If the department determines that the disorder should be included in the testing required under this section, commence rule making to add the disorder to the list under s. DHS 115.04, Wis. Adm. Code.

2. This paragraph does not apply to any disorder included in the federal recommended uniform screening panel that will be added to the list of disorders under s. DHS 115.04, Wis. Adm. Code, pending promulgation of a rule for which the department has commenced rule-making procedures as of the effective date of this subdivision .... [LRB inserts date].

(b) *Annual review.* 1. Subject to subd. 2., the department shall do all of the following on an annual basis for any disorder the department determines in an initial evaluation under par. (a) or a reevaluation under par. (c) should not be included in the testing required under this section and for any disorder that was the subject of rule making under par. (a) 2. or 2025 Wisconsin Act .... (this act), section 9119 (5), that did not result in the promulgation of a rule:

a. Review the medical literature published on the disorder since the initial evaluation or the commencement of rule making under par. (a) 2. or 2025 Wisconsin Act .... (this act), section 9119 (5), to determine whether new information has been identified that would merit a reevaluation of whether testing for the disorder should be included in the testing required under this section.

b. Determine whether the department has the capacity and resources needed to include testing for the disorder in the testing required under this section.

2. This paragraph does not apply to any disorder that is removed from the federal recommended uniform screening panel.

(c) *Reevaluation.* If the department finds in an annual review under par. (b) that new information has been identified that would merit a reevaluation of whether testing for a disorder should be included in the testing required under this section or that the department has the capacity and resources needed to include testing for the disorder in the testing required under this section, the department shall do all of the following within 18 months of completing the annual review:

1. Conduct a reevaluation to determine whether testing for the disorder should be included in the testing required under this section.

2. If the department determines in the reevaluation that testing for a disorder should be included in the testing required under this section, commence rule making to add the disorder to the list under s. DHS 115.04, Wis. Adm. Code.

(d) *Emergency rule making.* The department may use the procedure under s. 227.24 to promulgate a rule under this subsection or 2025 Wisconsin Act .... (this act), section 9119 (4) (b). Notwithstanding s. 227.24 (1) (a) and (3), the department is not required to provide evidence that promulgating a rule under this paragraph 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 paragraph. Notwithstanding s. 227.24 (1) (c) and (2), if the department submits in proposed form a permanent rule to the legislative council staff under s. 227.15 (1) within 15 months of the date the statement of scope of the emergency rule promulgated under this paragraph is published in the register under s. 227.135 (3), the emergency rule remains in effect until the date on which the permanent rule takes effect or the date on which the statement of scope expires under s. 227.135 (5), whichever occurs first.

(e) *Implementation.* The department shall ensure that testing for any disorder added by rule to the list under s. DHS 115.04, Wis. Adm. Code, in accordance with this subsection begins within 6 months after the date of publication, as defined in s. 227.22 (1), of the rule.

SECTION 146. 255.18 of the statutes is created to read:

255.18 Parkinson's disease registry reporting. (1) DEFINITIONS. In this section:

(a) "Health care facility" has the meaning given in s. 155.01 (6).

(b) "Health care provider" means a physician, surgeon, physician assistant, or nurse practitioner.

(c) "Parkinsonism" has the meaning given in s. 36.47 (1) (c)

(d) "Parkinson's disease" has the meaning given in s. 36.47 (1) (d).

(e) "Parkinson's disease registry" means the Parkinson's disease registry established and maintained by the Population Health Institute under s. 36.47 (3).

(f) "Population Health Institute" means the Population Health Institute, or its successor, at the University of Wisconsin-Madison School of Medicine and Public Health.

(2) REPORTING REQUIRED. Beginning on the first day of the 25th month beginning after the effective date of this subsection .... [LRB inserts date], if a health care provider diagnoses a patient with Parkinson's disease or a parkinsonism in this state or, for a health care provider who has primary responsibility for treating a patient's Parkinson's disease or parkinsonism, treats a patient's Parkinson's disease or parkinsonism in this state, that health care provider or the health care facility that employs or contracts with the health care provider shall do all of the following:

(a) Offer the patient the opportunity to do all of the following:

1. Review any informational materials developed by the Population Health Institute about the Parkinson's disease registry.

2. Speak with and ask questions of their health care provider about the Parkinson's disease registry.

3. Affirmatively decline, in writing, to participate in the collection of data for purposes of the Parkinson's disease registry.

(b) Except as provided in par. (d), report the information specified in the list under s. 36.47 (3) (d) about the patient's case to the Population Health Institute in the format prescribed by the Population Health Institute under s. 36.47 (3) (c).

(c) Notify the patient orally and in writing about the reporting requirement under par. (b).

(d) If the patient affirmatively declines in writing to participate in the collection of data for purposes of the Parkinson's disease registry, report only the incident of the patient's Parkinson's disease or parkinsonism to the Population Health Institute in the format prescribed by the Population Health Institute under s. 36.47 (3) (c).

(3) CONFIDENTIALITY. Any information reported to the Population Health Institute under sub. (2) that could identify an individual who is the subject of the report or a health care provider submitting the report is confidential. Confidential information obtained or reported in compliance with sub. (2) is not available for subpoena and may not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding. Confidential information obtained or reported in compliance with sub. (2) is not admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason.

(4) RESPONSIBILITY. A health care facility that employs or contracts with a health care provider diagnosing a patient with, or treating a patient with, Parkinson's disease or a parkinsonism is ultimately responsible for meeting the requirements under sub. (2).

SECTION 147. 255.35 (3) (a) of the statutes is amended to read:

255.35 **(3)** (a) The department shall implement a statewide poison control system, which shall provide poison control services that are available statewide, on a 24-hour per day and 365-day per year basis and shall provide poison information and education to health care professionals and the public. From the appropriation account under s. 20.435 (1) (ds), the department shall, if the requirement under par. (b) is met, distribute total funding of not more than ~~$425,000~~ $482,500 in each fiscal year to supplement the operation of the system and to provide for the statewide collection and reporting of poison control data. The department may, but need not, distribute all of the funds in each fiscal year to a single poison control center.

SECTION 148. 256.12 (4) (a) of the statutes is amended to read:

256.12 **(4)** (a) From the appropriation account under s. 20.435 (1) (r), the department shall annually distribute funds for ambulance service vehicles or vehicle equipment, emergency medical services supplies or equipment, nondurable or disposable medical supplies or equipment, medications, or emergency medical training for personnel to an emergency medical responder department or ambulance service provider that is a public agency, a volunteer fire department or a nonprofit corporation, under a funding formula consisting of ~~an identical~~ a base amount for each ~~emergency medical responder department or ambulance~~ service provider based on provider type, plus a supplemental amount based on the population or other relevant factors of the emergency medical responder department's primary service area or the population or other relevant factors of the

ambulance service provider's primary service or contract area, as established under s. 256.15 (5), as applicable.

SECTION 149. 256.12 (4) (c) of the statutes is amended to read:

256.12 **(4)** (c) Funds distributed under par. (a) or (b) shall supplement existing, budgeted moneys of or provided to an ambulance service provider and may not be used to replace, decrease or release for alternative purposes the existing, budgeted moneys of or provided to the ambulance service provider. A grant recipient under this subsection cannot expend more than 15 percent of a grant awarded during an annual grant cycle on nondurable or disposable medical supplies ~~or equipment~~ and medications. In order to ensure compliance with this paragraph, the department shall require, as a condition of relicensure, a financial report of expenditures under this subsection from ~~an ambulance service provider and may require a financial report of expenditures under this subsection from an emergency medical responder department or an owner or operator of an ambulance service or a public agency, volunteer fire department or a nonprofit corporation with which an ambulance service provider has contracted to provide ambulance services~~ grant recipients.

SECTION 150. 256.12 (5) (a) of the statutes is amended to read:

256.12 **(5)** (a) From the appropriation account under s. 20.435 (1) (r), the department shall annually distribute funds to emergency medical responder departments or ambulance service providers that are public agencies, volunteer fire departments, or nonprofit corporations to purchase the training required for licensure and renewal of licensure as an emergency medical technician under s. 256.15 (6) or for certification and renewal of certification as an emergency medical

responder under s. 256.15 (8), and to pay for administration of the examination required for licensure or renewal of licensure as an emergency medical ~~technician~~ services practitioner under s. 256.15 (6) (a) 3. and (b) 1. or certification or renewal of certification as an emergency medical responder under s. 256.15 (8).

SECTION 151. 256.12 (5) (am) of the statutes is amended to read:

256.12 **(5)** (am) If an emergency medical responder department or ambulance service provider does not use funds received under par. (a) within a calendar year, the emergency medical responder department or ambulance service provider may escrow those funds in the year in which the funds are distributed to the emergency medical responder department or ambulance service provider, except funds distributed for nondurable or disposable medical supplies ~~or equipment~~ or medications. In a subsequent year, an emergency medical responder department or ambulance service provider may use escrowed funds to purchase the training required for certification or renewal of certification as an emergency medical responder or licensure or renewal of licensure as an emergency medical services practitioner at any level or to pay for administration of the examination required for certification or renewal of certification as an emergency medical responder or for licensure or renewal of licensure as an emergency medical services practitioner at any level.

SECTION 152. 256.23 (5) of the statutes is amended to read:

256.23 **(5)** ~~In accordance with s. 20.940, the~~ The department shall submit to the federal department of health and human services a request for any state plan amendment, waiver or other approval that is required to implement this section and s. 49.45 (3) (em). If federal approval is required, the department may not

implement the collection of the fee under sub. (2) until it receives approval from the federal government to obtain federal matching funds.

SECTION 153. 256.42 of the statutes is created to read:

256.42 Emergency medical services grants. (1) In this section, "municipality" means a city, village, or town.

(2) From the appropriation under s. 20.435 (1) (ck), the department shall award grants each fiscal year to municipalities to improve or expand emergency medical services. From the moneys appropriated each fiscal year, the department shall do all of the following:

(a) Award 25 percent to municipalities to support the development of 24-7 paid service models in accordance with criteria developed by the department.

(b) Award the remaining amount using a formula consisting of a base amount, determined by the department, for each municipality, plus a supplemental amount based on the population of the municipality.

SECTION 154. 441.07 (1g) (f) of the statutes is repealed.

SECTION 155. 448.02 (3) (a) of the statutes is amended to read:

448.02 **(3)** (a) The board shall investigate allegations of unprofessional conduct and negligence in treatment by persons holding a license or certificate granted by the board. An allegation that a physician has violated s. ~~253.10 (3),~~ 448.30 or 450.13 (2) or has failed to mail or present a medical certification required under s. 69.18 (2) within 21 days after the pronouncement of death of the person who is the subject of the required certificate or that a physician has failed at least 6 times within a 6-month period to mail or present a medical certificate required under s. 69.18 (2) within 6 days after the pronouncement of death of the person who

is the subject of the required certificate is an allegation of unprofessional conduct. Information contained in reports filed with the board under s. 49.45 (2) (a) 12r., 50.36 (3) (b), 609.17 or 632.715, or under 42 CFR 1001.2005, shall be investigated by the board. Information contained in a report filed with the board under s. 655.045 (1), as created by 1985 Wisconsin Act 29, which is not a finding of negligence or in a report filed with the board under s. 50.36 (3) (c) may, within the discretion of the board, be used as the basis of an investigation of a person named in the report. The board may require a person holding a license or certificate to undergo and may consider the results of one or more physical, mental or professional competency examinations if the board believes that the results of any such examinations may be useful to the board in conducting its investigation.

SECTION 156. 448.02 (3) (a) of the statutes, as affected by 2023 Wisconsin Act 172, section 4, and 2025 Wisconsin Act .... (this act), is repealed and recreated to read:

448.02 **(3)** (a) The board shall investigate allegations of unprofessional conduct and negligence in treatment by persons holding a license or certificate granted by the board. An allegation that a physician has violated s. 448.30 or 450.13 (2) or has failed to present a medical certification required under s. 69.18 (2) within 21 days after the pronouncement of death of the person who is the subject of the required certificate or that a physician has failed at least 6 times within a 6-month period to present a medical certificate required under s. 69.18 (2) within 6 days after the pronouncement of death of the person who is the subject of the required certificate is an allegation of unprofessional conduct. Information contained in reports filed with the board under s. 49.45 (2) (a) 12r., 50.36 (3) (b),

609.17, or 632.715, or under 42 CFR 1001.2005, shall be investigated by the board. Information contained in a report filed with the board under s. 655.045 (1), as created by 1985 Wisconsin Act 29, which is not a finding of negligence or in a report filed with the board under s. 50.36 (3) (c) may, within the discretion of the board, be used as the basis of an investigation of a person named in the report. The board may require a person holding a license or certificate to undergo and may consider the results of one or more physical, mental or professional competency examinations if the board believes that the results of any such examinations may be useful to the board in conducting its investigation.

SECTION 157. 457.26 (2) (gm) of the statutes is repealed.

SECTION 158. 601.83 (1) (a) of the statutes is amended to read:

601.83 **(1)** (a) The commissioner shall administer a state-based reinsurance program known as the healthcare stability plan in accordance with the specific terms and conditions approved by the federal department of health and human services dated July 29, 2018. Before December 31, 2023, the commissioner may not request from the federal department of health and human services a modification, suspension, withdrawal, or termination of the waiver under 42 USC 18052 under which the healthcare stability plan under this subchapter operates unless legislation has been enacted specifically directing the modification, suspension, withdrawal, or termination. Before December 31, 2023, the commissioner may request renewal, without substantive change, of the waiver under 42 USC 18052 under which the health care stability plan operates ~~in accordance with s. 20.940 (4)~~ unless legislation has been enacted that is contrary to such a renewal request. ~~The commissioner shall comply with applicable timing in and requirements of s. 20.940.~~

SECTION 159. 609.835 of the statutes is created to read:

609.835 Coverage of prescription drugs and medical supplies to treat asthma. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.895 (16g).

SECTION 160. 632.895 (16g) of the statutes is created to read:

632.895 **(16g)** COVERAGE OF PRESCRIPTION DRUGS AND MEDICAL SUPPLIES TO TREAT ASTHMA. (a) In this subsection, "related medical supplies" includes asthma inhalers and other medical supply items necessary to effectively and appropriately administer a prescription drug prescribed to treat asthma.

(b) Subject to par. (c), every disability insurance policy and every self-insured health plan of the state or of a county, city, town, village, or school district that provides coverage of prescription drugs shall cover prescription drugs and related medical supplies for the treatment of asthma.

(c) A disability insurance policy or self-insured health plan of the state or of a county, city, town, village, or school district to which par. (b) applies shall limit the amount of any enrollee cost-sharing to no more than $25 per one-month supply for each prescription drug prescribed to treat asthma and to no more than $50 per month for all related medical supplies. The cost-sharing limitations under this paragraph may not increase with the number of conditions for which an enrollee is treated. Coverage under this subsection may not be subject to any deductible.

(d) If, under federal law, application of par. (c) would result in ineligibility for a health savings account under section 223 of the Internal Revenue Code, par. (c) shall apply to a health-savings-account-qualified high deductible health plan with respect to the deductible of such a plan only after the enrollee has satisfied the

minimum deductible under section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to section 223 (c) (2) (C) of the Internal Revenue Code, in which case par. (c) shall apply regardless of whether the minimum deductible under section 223 of the Internal Revenue Code has been satisfied.

SECTION 161. 632.8985 of the statutes is repealed.

SECTION 162. 939.75 (2) (b) 1. of the statutes is amended to read:

939.75 **(2)** (b) 1. An act committed during an induced abortion. This subdivision does not limit the applicability of ss. ~~940.04,~~ 940.13, 940.15 and 940.16 to an induced abortion.

SECTION 163. 940.04 of the statutes is repealed.

SECTION 164. 940.15 (5) of the statutes is repealed.

SECTION 165. 968.26 (1b) (a) 2. a. of the statutes is amended to read:

968.26 **(1b)** (a) 2. a. Section ~~940.04,~~ 940.11, 940.19 (2), (4), (5), or (6), 940.195 (2), (4), (5), or (6), 940.198 (2) (b) or (c) or (3), 940.20, 940.201, 940.203, 940.204, 940.205, 940.207, 940.208, 940.22 (2), 940.225 (3), 940.29, 940.302 (2) (c), 940.32, 941.32, 941.38 (2), 942.09 (2), 943.10, 943.205, 943.32 (1), 946.43, 946.44, 946.47, 946.48, 948.02 (3), 948.03 (2) (b) or (c), (3), or (4), 948.04, 948.055, 948.095, 948.10 (1) (a), 948.11, 948.13 (2) (a), 948.14, 948.20, 948.23 (1), (2), or (3) (c) 2. or 3., or 948.30 (1).

SECTION 166. DHS 107.07 (4) (k) 2. of the administrative code is repealed.

SECTION 167. 2017 Wisconsin Act 370, section 44 (2) and (3) are repealed.

SECTION 168. 2017 Wisconsin Act 370, section 44 (5) is repealed.

SECTION 9119. Nonstatutory provisions; Health Services.

(1) 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), 2023 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. The department of health services may submit a request to the federal department of health and human services to modify or withdraw from the waiver granted under s. 49.45 (23) (g), 2023 stats.

(2) RULES REGARDING TRAINING OF CERTIFIED PEER SPECIALISTS. The department of health services may promulgate the rules required under s. 49.45 (30j) (bm) 4. 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. Notwithstanding s. 227.24 (1) (c) and (2), emergency rules promulgated under this subsection remain in effect until January 1, 2027, or the date the permanent rules take effect, whichever is sooner.

(3) COMPLEX PATIENT PILOT PROGRAM.

(a) In this subsection:

1. "Department" means the department of health services.

2. "Partnership group" means one or more hospitals in partnership with one or more post-acute facilities.

(b) The department shall use a competitive grant selection process to select partnership groups to be designated as participating sites for a complex patient pilot program under this subsection and, from the appropriation under s. 20.435 (7) (d), award grants to the groups selected.

(c) The department shall solicit feedback regarding the complex patient pilot program from representatives of healthcare system organizations, long-term care provider organizations, long-term care operator organizations, patient advocate groups, insurers, and any other organization determined to be relevant by the secretary of health services.

(d) The department shall require that each partnership group that applies to the department to be designated as a site for the complex patient pilot program shall address all of the following issues in its application:

1. The number of complex patient care beds that will be set aside in a post-acute facility or through implementation of an innovative model of patient care in a post-acute facility to which participating hospitals agree, such as dedicated staffing for dementia or a behavioral health unit.

2. Defined goals and measurable outcomes of the partnership group during the pilot program and after the pilot program.

3. The types of complex patients for whom care will be provided, which may include patients needing total care for multiple conditions or comorbidities such as

cardiac and respiratory diseases, obesity, mental health, substance use, or dementia.

4. An operating budget for the proposed site that details how fiscal responsibility will be shared among members of the partnership group and includes all of the following:

a. Estimated patient revenues from other sources, including the Medical Assistance program under subch. IV of ch. 49, and estimated total costs.

b. A margin to account for reserved beds.

5. The partnership group's expertise to successfully implement the proposal, which may include a discussion of the following issues:

a. Documented experience of the partners working together to serve complex patients.

b. The implementation timeline and the plan for post-acute facilities to accept admissions and transfer patients within 72 hours of a request submitted by a hospital.

c. The plan for an interdisciplinary team that will staff the unit in the post-acute facility, including the availability of staff with appropriate expertise that includes physicians, nurses, advance practice health professionals, pharmacists, physical therapists, occupational therapists, and social workers.

d. Ability to electronically exchange health information.

e. Resources to conduct patient intake and discharge planning from the post-acute facility, including case managers and social workers.

f. Ability to conduct monthly case management reviews with the

interdisciplinary team for every complex care patient that cover care plan progress and any readmissions to an acute care hospital.

g. Ability to conduct monthly quality assurance reviews.

h. Ability of the treatment model to be replicated by other healthcare systems.

i. Plans to document decreases in lengths of stay for complex patients in hospitals and avoided hospital days.

j. Documentation of stable finances among partnership group members to support the proposal, including matching funds that could be dedicated to the pilot program under this subsection. No applicant may be required to provide matching funds or a contribution, but the department may take into consideration the availability of matching funds or a contribution in evaluating an application.

k. Description of anticipated impediments to successful implementation and how the partnership group intends to overcome the anticipated impediments.

(e) In implementing this subsection, the department shall do all of the following:

1. Develop a methodology to evaluate the complex patient pilot program and contract with an independent organization to complete the evaluation. The department may pay the fee of the organization selected from the appropriation under s. 20.435 (7) (d).

2. Give additional weight to partnership groups that would ensure geographic diversity.

(f) Upon completion of the evaluation required under par. (e) 1., the

independent organization contracted by the department to complete the evaluation shall provide the evaluation to the department.

(4) NEWBORN SCREENING PROGRAM; CONDITIONS APPROVED AS OF JANUARY 1, 2025. For any disorder included in the federal recommended uniform screening panel approved by the federal department of health and human services as of January 1, 2025, that is not included in the list of disorders under s. DHS 115.04, Wis. Adm. Code, on the effective date of this subsection, the department of health services shall do all of the following within 18 months of the effective date of this subsection:

(a) Evaluate whether the disorder should be included in the testing required under s. 253.13 (1).

(b) If, in its evaluation, the department of health services determines that the disorder should be included in the testing required under s. 253.13 (1), commence rule making to add the disorder to the list under s. DHS 115.04, Wis. Adm. Code.

(5) NEWBORN SCREENING PROGRAM; PENDING RULE PROMULGATION. Subsection (4) does not apply to any disorder included in the federal recommended uniform screening panel that will be added to the list of disorders under s. DHS 115.04, Wis. Adm. Code, pending promulgation of a rule for which the department of health services has commenced the rule-making procedure as of the effective date of this subsection.

(6) NEWBORN SCREENING PROGRAM; TESTING START DATE. The department of health services shall ensure that testing for any disorder added by rule to the list under s. DHS 115.04, Wis. Adm. Code, in accordance with sub. (4) begins within 6 months after the date of publication, as defined in s. 227.22 (1), of the rule.

(7) EMERGENCY RULES ON PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES. The department of health services may promulgate emergency rules under s. 227.24 implementing certification of psychiatric residential treatment facilities under s. 51.044, including development of a new provider type and a reimbursement model for psychiatric residential treatment facilities under the Medical Assistance program under subch. IV of ch. 49. 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. Notwithstanding s. 227.24 (1) (c) and (2), emergency rules promulgated under this subsection remain in effect until July 1, 2027, or the date on which permanent rules take effect, whichever is sooner.

(8) ELECTROCARDIOGRAM SCREENING PILOT PROGRAM. The department of health services shall develop a pilot program to provide electrocardiogram screenings for participants in middle school and high school athletics programs in Milwaukee and Waukesha Counties. From the appropriation under s. 20.435 (1) (b), in fiscal year 2026-27, the department shall award $4,067,200 in grants to local health departments, as defined under s. 250.01 (4), to implement the pilot program under this subsection. Participation in the pilot program by participants in middle school and high school athletics programs shall be optional.

(9) HEALTH CARE PROVIDER INNOVATION GRANTS. From the appropriation under s. 20.435 (4) (bm), the department of health services shall award $7,500,000

in fiscal year 2025-26 as grants to health care providers and long-term care providers to implement best practices and innovative solutions to increase worker recruitment and retention.

(10) FALLS PREVENTION FUNDING. From the appropriation under s. 20.435 (1) (b), the department of health services shall award a grant of $450,000 in each of fiscal years 2025-26 and 2026-27 to an organization committed to reducing falls among older adults in this state for the purpose of statewide falls prevention awareness and initiatives.

(11) REFERENCE CHANGES. Wherever a reference to s. 253.10 (2) (a) appears in the statutes, the legislative reference bureau shall substitute a reference to s. 69.01 (13m), as it defines the term "induced abortion."

(12) POSITIONS. The authorized positions for the department of health services are increased as provided in 2025 Senate Bill 45.

(13) FUNDING At the appropriate place, replace the schedule for s. 20.435 with the schedule for 2025 Senate Bill 45 covering the department of health services.

SECTION 9123. Nonstatutory provisions; Insurance.

(1) POSITIONS. The authorized positions for office of the commissioner of insurance are increased as provided in 2025 Senate Bill 45.

(2) FUNDING. At the appropriate place, replace the schedule for s. 20.145 with the schedule for 2025 Senate Bill 45 covering the office of the commissioner of insurance.

SECTION 9147. Nonstatutory provisions; University of Wisconsin System.

(1) FUNDING ALLOCATION FOR A STATEWIDE PARKINSON'S DISEASE REGISTRY. From the appropriation under s. 20.285 (1) (a), the Board of Regents of the University of Wisconsin System shall allocate in fiscal year 2025-26, at least $3,900,000, and in fiscal year 2026-27, at least $2,400,000, to establish the statewide Parkinson's disease registry under s. 36.47.

SECTION 9219. Fiscal changes; Health Services.

(1) EXTENDED INTENSIVE TREATMENT SURCHARGE BALANCE TRANSFER. The unencumbered balance in the appropriation account under s. 20.435 (2) (gL), 2023 stats., is transferred to the appropriation account under s. 20.435 (2) (g).

(2) WINNEBAGO MENTAL HEALTH INSTITUTE. There is transferred from the general fund to the appropriation account under s. 20.435 (2) (gk) $18,599,500 in fiscal year 2025-26 and $15,251,000 in fiscal year 2026-27 to support the operations of Winnebago Mental Health Institute.

SECTION 9319. Initial applicability; Health Services.

(1) SUPPORT AND IMPROVEMENT OF EMERGENCY MEDICAL SERVICES. The treatment of s. 256.12 (4) (a) and (c) of this act first applies to funds distributed under s. 256.12 (4) (a) on the effective date of this subsection.

(2) EMERGENCY MEDICAL SERVICES TRAINING AND EXAMINATION AID. The treatment of s. 256.12 (5) (a) and (am) first applies to funds distributed under s. 256.12 (5) (a) on the effective date of this subsection.

(3) MEDICAID SCHOOL-BASED SERVICES. The treatment of s. 49.45 (39) (b) 1. and 2. first applies to claims for reimbursement submitted on July 1, 2026.

(4) DETERMINATION OF MEDICAL ASSISTANCE ELIGIBILITY BY INDICATING

INTEREST ON AN INDIVIDUAL INCOME TAX RETURN. The treatment of ss. 71.03 (9) and 71.78 (4) (w) first applies to taxable years beginning after December 31, 2025.

(5) ABORTION COVERAGE.

(a) For policies and plans containing provisions inconsistent with s. 40.51 (9m), s. 40.51 (9m) first applies to policy or plan years beginning on the effective date of this subsection, except as provided in par. (b).

(b) For policies and plans that are affected by a collective bargaining agreement containing provisions inconsistent with s. 40.51 (9m), s. 40.51 (9m) first applies to policy or plan years beginning on the effective date of this subsection or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 9323. Initial applicability; Insurance.

(1) COVERAGE OF ASTHMA DRUGS AND SUPPLIES.

(a) For policies and plans containing provisions inconsistent with this act, the treatment of ss. 609.835 and 632.895 (16g) first applies to policy or plan years beginning on the effective paragraph of this subsection, except as provided in par. (b).

(b) For policies and plans that are affected by a collective bargaining agreement containing provisions inconsistent with this act, the treatment of ss. 609.835 and 632.895 (16g) 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.

SECTION 9419. Effective dates; Health Services.

(1) MEDICAID EXPANSION. The treatment of ss. 20.435 (4) (jw), 49.45 (23) and

(23b), 49.471 (1) (cr), (4) (a) 4. b. and 8., and (4g), and 49.686 (3) (d) and SECTION 9119 (1) of this act take effect on July 1, 2025.

(2) HEALTHCARE OWNERSHIP AND TRANSPARENCY. The creation of subch. IX of ch. 150, ss. 150.99, 150.992, 150.994, and 150.996 takes effect on January 1, 2027.

(3) TRAUMA RESILIENCE GRANT. The repeal of s. 46.48 (21) takes effect on July 1, 2027.

(4) MEDICAL EXAMINING BOARD AUTHORITY. The repeal and recreation of s. 448.02 (3) (a) takes effect on March 1, 2026.

SECTION 9423. Effective dates; Insurance.

(1) COVERAGE OF ASTHMA DRUGS AND SUPPLIES. The treatment of ss. 609.835 and 632.895 (16g) takes effect on the first day of the 4th month beginning after publication.

SECTION 9437. Effective dates; Revenue.

(1) OVER-THE-COUNTER DRUGS. The treatment of ss. 77.51 (9rm) and 77.54 (14) (g) takes effect on the first day of the 3rd month beginning after publication.".

2. At the appropriate places, insert all of the following:

"**SECTION 169.** 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 170. 15.732 of the statutes is created to read:

15.732 Same; attached office. (1) OFFICE OF THE PUBLIC INTERVENOR. There is created an office of the public intervenor which is attached to the office of the commissioner of insurance.

SECTION 171. 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), except for a member appointed under sub. (1) (b), 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).

SECTION 172. 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 173. 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 174. 20.145 (1) (g) 1. of the statutes is amended to read:

20.145 **(1)** (g) 1. All moneys received under ss. 601.25 (2), 601.31, 601.32, 601.42 (7), 601.45, and 601.47 and by the commissioner for expenses related to insurance company restructurings, except for restructurings specified in par. (h).

SECTION 175. 20.145 (1) (g) 4. of the statutes is created to read:

20.145 **(1)** (g) 4. All moneys received under s. 601.59.

SECTION 176. 20.145 (1) (g) 5. of the statutes is created to read:

20.145 **(1)** (g) 5. All moneys received from the regulation of pharmacy benefit managers, pharmacy benefit management brokers, pharmacy benefit management consultants, pharmacy services administration organizations, and pharmaceutical representatives.

SECTION 177. 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), 632.722, 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.7498, 632.798, 632.83, 632.835, 632.848, 632.85, 632.851, 632.853, 632.855, 632.861, 632.862, 632.867, 632.87 (3) to ~~(6)~~ (8), 632.871, 632.885, 632.89, 632.891, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 178. 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, 632.722, 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.7498, 632.798, 632.83, 632.835, 632.848, 632.85, 632.851, 632.853, 632.855, 632.861, 632.862, 632.867, 632.87 (4e), (7), and (8), 632.871, 632.885, 632.89, 632.891, and 632.895 (11) to (17).

SECTION 179. 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), 632.722, 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.7498, 632.798, 632.848, 632.85, 632.851, 632.853, 632.855, 632.861, 632.862, 632.867, 632.87 (4) to

~~(6)~~ (8), 632.871, 632.885, 632.89, 632.891, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 180. 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), 632.722, 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.7498, 632.798, 632.848, 632.85, 632.851, 632.853, 632.855, 632.861, 632.862, 632.867, 632.87 (4) to ~~(6)~~ (8), 632.871, 632.885, 632.89, 632.891, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 181. 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), 632.722, 632.729, 632.745 to 632.749, 632.7498, 632.775, 632.79, 632.795, 632.798, 632.848, 632.85, 632.851, 632.853, 632.855, 632.861, 632.862, 632.867, 632.87 (2) to ~~(6)~~ (8), 632.871, 632.885, 632.89, 632.891, 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 182. 601.25 of the statutes is created to read:

601.25 Office of the public intervenor. (1) The office of the public intervenor shall assist individuals with insurance claims, policies, appeals, and other legal actions to pursue insurance coverage for medical procedures, prescription medications, and other health care services.

(2) The office of the public intervenor may levy an assessment on each insurer

that is authorized to engage in the business of insurance in this state. The assessment levied under this subsection shall be based on the insurer's premium volume for disability insurance policies, as defined in s. 632.895 (1) (a), written in this state.

(3) The commissioner may provide by rule for the governance, duties, and administration of the office of the public intervenor.

SECTION 183. 601.31 (1) (mv) of the statutes is created to read:

601.31 **(1)** (mv) For initial issuance or renewal of a license as a pharmacy benefit management broker or consultant under s. 628.495, amounts set by the commissioner by rule.

SECTION 184. 601.31 (1) (nv) of the statutes is created to read:

601.31 **(1)** (nv) For issuing or renewing a license as a pharmaceutical representative under s. 632.863, an amount to be set by the commissioner by rule.

SECTION 185. 601.31 (1) (nw) of the statutes is created to read:

601.31 **(1)** (nw) For issuing or renewing a license as a pharmacy services administrative organization under s. 632.864, an amount to be set by the commissioner by rule.

SECTION 186. 601.41 (14) of the statutes is created to read:

601.41 **(14)** 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 187. 601.45 (1) of the statutes is amended to read:

601.45 **(1)** COSTS TO BE PAID BY EXAMINEES. The reasonable costs of examinations and audits under ss. 601.43, 601.44, 601.455, and 601.83 (5) (f) shall be paid by examinees except as provided in sub. (4), either on the basis of a system of billing for actual salaries and expenses of examiners and other apportionable expenses, including office overhead, or by a system of regular annual billings to cover the costs relating to a group of companies, or a combination of such systems, as the commissioner may by rule prescribe. Additional funding, if any, shall be governed by s. 601.32. The commissioner shall schedule annual hearings under s. 601.41 (5) to review current problems in the area of examinations.

SECTION 188. 601.455 of the statutes is created to read:

601.455 Fair claims processing, health insurance transparency, and claim denial rate audits. (1) DEFINITIONS. In this section:

(a) "Claim denial" means the refusal by an insurer to provide payment under a disability insurance policy for a service, treatment, or medication recommended by a health care provider. "Claim denial" includes the prospective refusal to pay for a service, treatment, or medication when a disability insurance policy requires advance approval before a prescribed medical service, treatment, or medication is provided.

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

(c) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (p).

(2) CLAIMS PROCESSING. (a) Insurers shall process each claim for a disability insurance policy within a time frame that is reasonable and prevents an undue delay in an insured's care, taking into account the medical urgency of the claim.

(b) If an insurer determines additional information is needed to process a claim for a disability insurance policy, the insurer shall request the information from the insured within 5 business days of making the determination and shall provide at least 15 days for the insured to respond.

(c) All claim denials shall include all of the following:

1. A specific and detailed explanation of the reason for the denial that cites the exact medical or policy basis for the denial.

2. A copy of or a publicly accessible link to any policy, coverage rules, clinical guidelines, or medical evidence relied upon in making the denial decision, with specific citation to the provision justifying the denial.

3. Additional documentation, medical rationale, or criteria that must be met or provided for approval of the claim, including alternative options available under the policy.

(d) If an insurer uses artificial intelligence or algorithmic decision-making in processing a claim for a disability insurance policy, the insurer must notify the insured in writing of that fact. The notice shall include all of the following:

1. A disclosure that artificial intelligence or algorithmic decision-making was used at any stage in reviewing the claim, even if a human later reviewed the outcome.

2. A detailed explanation of how the artificial intelligence or algorithmic decision-making reached its decision, including any factors the artificial intelligence or algorithmic decision-making weighed.

3. A contact point for requesting a human review of the claim if the claim was denied.

(3) INDEPENDENT REVIEW OF DENIALS. In addition to an insured's right to an independent review under s. 632.835, as applicable, insureds have the right to request a review by the office of the public intervenor of any claim denial.

(4) PROHIBITED PRACTICES. An insurer may not do any of the following with respect to a disability insurance policy:

(a) Use vague or misleading policy terms to justify a claim denial.

(b) Fail to provide a specific and comprehensible reason for a claim denial.

(c) Cancel coverage under the policy after a claim is submitted due to alleged misstatements on the policy application.

(d) Deny a claim based on hidden or ambiguous exclusions in a disability insurance policy.

(e) Stall review of a claim to avoid timely payment.

(f) Reject a claim without reviewing all relevant medical records or consulting qualified experts.

(g) Fail to properly review or respond to an insured's appeal in a timely manner.

(h) Allow non-physician personnel to determine whether care is medically necessary.

(i) Apply different medical necessity criteria based on financial interests rather than patient needs.

(j) Disregard a treating health care provider's medical assessment without a valid clinical reason.

(k) Mandate prior approval for routine or urgent procedures in a manner that causes harmful delays.

(L) For a disability insurance policy that provides coverage of emergency medical services, refuse to cover emergency medical services provided by out-of-network providers.

(m) List a health care provider as in-network on a provider directory and then deny a claim by stating the health care provider is out-of-network.

(n) Deny coverage based on age, gender, disability, or a chronic condition rather than medical necessity.

(o) Apply stricter standards in reviewing claims related to mental health conditions than claims related to physical health conditions.

(p) Perform a blanket denial of claims for high-cost conditions without an individualized review of each claim.

(r) Reclassify a claim to a lower-cost treatment to reduce insurer payout.

(s) Require an insured to fail a cheaper treatment before approving coverage for necessary care.

(t) Manipulate cost-sharing rules to shift higher costs to insureds.

(5) TRANSPARENCY AND REPORTING. (a) Beginning on January 1, 2027, an insurer shall annually publish a report detailing the insurer's claim denial rates, reasons for claim denials, and the outcome of any appeal of a claim denial for the previous year for all disability insurance policies under which the insurer provides coverage.

(b) The commissioner shall maintain a public database of insurers' claim denial rates and the outcomes of independent reviews under s. 632.835.

(c) Beginning on January 1, 2027, an insurer that uses artificial intelligence or algorithmic decision-making in claims processing shall annually publish a report

detailing all of the following for the previous year for all disability insurance policies under which the insurer provides coverage:

1. The percentage of claims submitted to the insurer that were reviewed by artificial intelligence or algorithmic decision-making.

2. The claim denial rate of claims reviewed by artificial intelligence or algorithmic decision-making compared to the claim denial rate of claims reviewed by humans.

3. The steps the insurer takes to ensure fairness and accuracy in decisions made by artificial intelligence or algorithmic decision-making.

(6) CLAIM DENIAL RATE AUDITS. (a) The commissioner may conduct an audit of an insurer if the insurer's claim denials are of such frequency as to indicate a general business practice. This paragraph is supplemental to and does not limit any other powers or duties of the commissioner.

(b) The commissioner may collect any relevant information from an insurer that is necessary to conduct an audit under par. (a).

(c) The commissioner may contract with a 3rd party to conduct an audit under par. (a).

(d) The commissioner may, based on the findings of an audit under par. (a), order the insurer who is the subject of the audit to comply with a corrective action plan approved by the commissioner. The commissioner shall specify in any corrective action plan under this paragraph the deadline by which an insurer must be in compliance with the corrective action plan.

(e) An insurer who is the subject of an audit under par. (a) shall provide a written response to any adverse findings of the audit.

(f) If an insurer fails to comply with a corrective action plan under par. (d) by the deadline specified by the commissioner, the commissioner may order the insurer to pay a forfeiture pursuant to s. 601.64 (3).

(7) FORFEITURES. A violation of this section that results in a harmful delay in an insured's care or an adverse health outcome for an insured shall be subject to a civil forfeiture of $10,000 per occurrence, in addition to any other penalties provided in s. 601.64 (3) or other law.

SECTION 189. 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 program shall comply with relevant requirements of 21 USC 384, including safety and cost savings requirements.

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

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

(e) The program shall import only those prescription drugs for which

importation creates substantial savings for residents of this 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 are not distributed, dispensed, or sold outside of this state.

(g) The program 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 program 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 program 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 plan or policy are affected by savings on prescription drugs imported under the program.

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

(k) The program may not import any generic prescription drug that would violate federal patent laws on branded products in the United States.

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

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

(n) The program 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 program.

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 program is complying with the requirements of this subsection.

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

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

7. The program provides and is projected to continue to provide substantial cost savings to residents of this 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 program to the federal department of health and human services unless the joint committee on finance approves the proposed program. Within 14 days of the date of approval by the joint committee on finance of the proposed program, the commissioner shall submit to the federal department of health and human services a request for certification of the approved 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 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 this state on participating in the 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 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 program.

(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 prescription drug 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 this 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 190. 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 for which 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 equal to the user fee rate the federal department of health and human services specifies under 45 CFR 156.50 (c) (1) for the federally facilitated exchanges for the applicable plan year.

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

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

SECTION 191. 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

SECTION 192. 601.78 of the statutes is created to read:

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) "Financial benefit" includes an honorarium, fee, stock, the value of the stock holdings of a member of the board or any immediate family member of the member of the board, and any direct financial benefit deriving from the finding of a review conducted under s. 601.79.

(6) "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.

(7) "Immediate family member" means a spouse, grandparent, parent, sibling, child, stepchild, or grandchild or the spouse of a grandparent, parent, sibling, child, stepchild, or grandchild.

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

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

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

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

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

SECTION 193. 601.785 of the statutes is created to read:

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 in the manner described in subd. 2., except that the chairperson 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 do any of the following:

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.

(c) The board shall establish and maintain a website to provide public notices and make meeting materials available under sub. (3) (a) and to disclose conflicts of interest under sub. (4) (d).

(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 of the member 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 under this subsection 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 decision relating to a review of a prescription drug product.

(c) A conflict of interest under this subsection 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 website unless the chairperson of the board recuses the member from a final decision relating to 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.

SECTION 194. 601.79 of the statutes is created to read:

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.

(b) 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 wholesale acquisition cost that has increased by at least $3,000 during a 12-month period.

(c) A biosimilar 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.

(d) 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 federal food and drug administration, a supply lasting a patient for a period of 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.

(e) 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 used 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 under par. (b) 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 under sub. (2), 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 percentage 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 percentage of the wholesale acquisition cost.

(d) The price at which therapeutic alternatives to the prescription drug product 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 to the prescription drug product.

(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 to the prescription drug product.

(j) The average patient copay or other cost sharing for the prescription drug product in this 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) (b) or (d) 2., 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.

SECTION 195. 601.83 (1) (h) of the statutes is renumbered 601.83 (1) (h) (intro.) and amended to read:

601.83 **(1)** (h) (intro.) ~~In 2019 and in each subsequent year, the~~ The commissioner may expend no more than ~~$200,000,000~~ the following amounts from all revenue sources for the healthcare stability plan under this section, unless the ~~joint committee on finance under s. 13.10~~ governor has increased this amount upon request by the commissioner~~.~~:

(he) The commissioner shall ensure that sufficient funds are available for the healthcare stability plan under this section to operate as described in the approval of the federal department of health and human services dated July 29, 2018, and in any waiver extension approvals.

SECTION 196. 601.83 (1) (h) 1. to 3. of the statutes are created to read:

601.83 **(1)** (h) 1. In 2025, $230,000,000.

2. In 2026, $250,000,000.

3. In 2027 and in each year thereafter, the maximum expenditure amount for the previous year, adjusted to reflect the percentage increase, if any, in the consumer price index for all urban consumers, U.S. city average, for the medical

care group, as determined by the U.S. department of labor, for the 12-month period ending on December 31 of the year before the year in which the amount is determined. The commissioner shall determine the annual adjustment amount for a particular year in January of the previous year. The commissioner shall publish the new maximum expenditure amount under this subdivision each year in the Wisconsin Administrative Register.

SECTION 197. 601.83 (1) (hm) of the statutes is repealed.

SECTION 198. 609.04 of the statutes is created to read:

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

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

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

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

b. Serious impairment of bodily function.

c. Serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

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

(2) EMERGENCY MEDICAL SERVICES. A defined network plan, preferred provider plan, or self-insured governmental plan that covers any benefits or services provided in an emergency department of a hospital or emergency medical

services provided in an independent freestanding emergency department shall cover emergency medical services in accordance with all of the following:

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

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

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

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

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

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

4. The plan does all of the following:

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

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

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

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

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

(b) Any cost-sharing amount imposed on an enrollee for the item or service is calculated as if the total amount that would have been charged for the item or

service if provided by a participating provider is equal to the recognized amount for such item or service, plan or coverage, and year.

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

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

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

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

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

2. The notice provides a good faith estimate of the amount that the nonparticipating provider may charge the enrollee for the item or service involved,

including notification that the estimate does not constitute a contract with respect to the charges estimated for the item or service.

3. The notice includes a list of the participating providers at the participating facility who would be able to provide the item or service and notification that the enrollee may be referred to one of those participating providers.

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

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

6. The notice is worded in plain language.

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

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

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

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

1. If the enrollee makes an appointment for the item or service at least 72

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

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

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

1. Related to an emergency medical service.

2. Anesthesiology.

3. Pathology.

4. Radiology.

5. Neonatology.

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

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

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

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

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

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

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

(6) NEGOTIATION; DISPUTE RESOLUTION. A provider or facility that is entitled to receive an initial payment or notice of denial under sub. (2) (c) 4. a. or (3) (c) may initiate, within 30 days of receiving the initial payment or notice of denial, open negotiations with the defined network plan, preferred provider plan, or self-insured governmental plan to determine a payment amount for an emergency medical

service or other item or service for a period that terminates 30 days after initiating open negotiations. If the open negotiation period under this subsection terminates without determination of a payment amount, the provider, facility, defined network plan, preferred provider plan, or self-insured governmental plan may initiate, within the 4 days beginning on the day after the open negotiation period ends, the independent dispute resolution process as specified by the commissioner. If the independent dispute resolution decision-maker determines the payment amount, the party to the independent dispute resolution process whose amount was not selected shall pay the fees for the independent dispute resolution. If the parties to the independent dispute resolution reach a settlement on the payment amount, the parties to the independent dispute resolution shall equally divide the payment for the fees for the independent dispute resolution.

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

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

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

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

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

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

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

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

a. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.

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

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

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

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

3. Allow the enrollee to elect to continue to have the benefits provided under

the plan under the same terms and conditions as would have applied to the item or service if the termination had not occurred for the course of treatment related to the enrollee's status as a continuing care patient beginning on the date on which the notice under subd. 1. is provided and ending 90 days after the date on which the notice under subd. 1. is provided or the date on which the enrollee is no longer a continuing care patient, whichever is earlier.

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

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

SECTION 199. 609.20 (3) of the statutes is created to read:

609.20 **(3)** The commissioner may promulgate rules to establish minimum network time and distance standards and minimum network wait-time standards for defined network plans and preferred provider plans. In promulgating rules under this subsection, the commissioner shall consider standards adopted by the federal centers for medicare and medicaid services for qualified health plans, as

defined in 42 USC 18021 (a), that are offered through the federal health insurance exchange established pursuant to 42 USC 18041 (c).

SECTION 200. 609.24 (5) of the statutes is created to read:

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

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

(b) Subsection (1) (c) shall apply to lengthen the period in which benefits are provided under s. 609.04 (7) (b) 3. but may not be applied to shorten the period in which benefits are provided under s. 609.04 (7) (b) 3.

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

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

SECTION 201. 609.40 of the statutes is created to read:

609.40 Special enrollment period for pregnancy. Preferred provider plans and defined network plans are subject to s. 632.7498.

SECTION 202. 609.712 of the statutes is created to read:

609.712 Essential health benefits; preventive services. Defined

network plans and preferred provider plans are subject to s. 632.895 (13m) and (14m).

SECTION 203. 609.713 of the statutes is created to read:

609.713 Qualified treatment trainee coverage. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.87 (7).

SECTION 204. 609.714 of the statutes is created to read:

609.714 Substance abuse counselor coverage. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.87 (8).

SECTION 205. 609.718 of the statutes is created to read:

609.718 Dental therapist coverage. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.87 (4e).

SECTION 206. 609.719 of the statutes is created to read:

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

SECTION 207. 609.74 of the statutes is created to read:

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

SECTION 208. 609.815 of the statutes is created to read:

609.815 Exemption from prior authorization requirements. Limited service health organizations, preferred provider plans, and defined network plans are subject to any rules promulgated by the commissioner under s. 632.848.

SECTION 209. 609.823 of the statutes is created to read:

609.823 Coverage without prior authorization for inpatient mental health services. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.891.

SECTION 210. 609.825 of the statutes is created to read:

609.825 Coverage of emergency ambulance services. (1) In this section:

(a) "Ambulance service provider" has the meaning given in s. 256.01 (3).

(b) "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) A defined network plan, preferred provider plan, or self-insured governmental plan that provides coverage of emergency medical services shall cover emergency ambulance services provided by an ambulance service provider that is not a participating provider at a rate that is not lower than the greatest rate that is any of the following:

(a) A rate that is set or approved by a local governmental entity in the jurisdiction in which the emergency ambulance services originated.

(b) A rate that is 400 percent of the current published rate for the provided emergency ambulance services established by the federal centers for medicare and medicaid services under title XVIII of the federal Social Security Act, 42 USC 1395 et seq., in the same geographic area or a rate that is equivalent to the rate billed by

the ambulance service provider for emergency ambulance services provided, whichever is less.

(c) The contracted rate at which the defined network plan, preferred provider plan, or self-insured governmental plan would reimburse a participating ambulance service provider for the same emergency ambulance services.

(3) No defined network plan, preferred provider plan, or self-insured governmental plan may impose a cost-sharing amount on an enrollee for emergency ambulance services provided by an ambulance service provider that is not a participating provider at a rate that is greater than the requirements that would apply if the emergency ambulance services were provided by a participating ambulance service provider.

(4) No ambulance service provider that receives reimbursement under this section may bill an enrollee for any additional amount for emergency ambulance services except for any copayment, coinsurance, deductible, or other cost-sharing responsibilities required to be paid by the enrollee.

(5) For purposes of this section, "emergency ambulance services" does not include air ambulance services.

SECTION 211. 609.83 of the statutes 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 212. 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 213. 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 214. 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 215. 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 216. 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 217. 628.34 (3) (a) of the statutes is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ss. 632.365, 632.728, 632.729, 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 218. 628.42 of the statutes is created to read:

628.42 Disclosure and review of prior authorization requirements. **(1)** In this section:

(a) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(b) 1. "Prior authorization" means the process by which a health care plan or a contracted utilization review organization determines the medical necessity and medical appropriateness of otherwise covered health care services.

2. "Prior authorization" includes any requirement that an enrollee or provider notify the health care plan or a contracted utilization review organization before, at the time of, or concurrent to providing a health care service.

(b) "Provider" has the meaning given in s. 628.36 (2) (a) 2.

(2) (a) A health care plan shall maintain a complete list of services for which prior authorization is required, including services where prior authorization is performed by an entity under contract with the health care plan.

(b) A health care plan shall publish the list under par. (a) on its website. The list shall be accessible by members of the general public without requiring the creation of any of an account or the entry of any credentials or personal information.

(c) The list under par. (a) is not required to contain any clinical review criteria applicable to the services.

(3) (a) A health care plan shall make any current prior authorization requirements and restrictions along with the clinical review criteria applicable to those requirements or restrictions accessible and conspicuously posted on its website to enrollees and providers. Content published by a 3rd party and licensed for use by a health care plan or a contracted utilization review organization may satisfy this subsection if it is available to access through the website of the health care plan or the contracted utilization review organization as long as the website does not unreasonably restrict access.

(b) The prior authorization requirements and restrictions under par. (a) shall be described in detail, and shall be written in easily understandable, plain language.

(c) The prior authorization requirements and restrictions under par. (a) shall indicate all of the following for each service subject to the prior authorization requirements and restrictions:

1. When the requirement or restriction began for policies issued or delivered in this state, including effective dates and any termination dates.

2. The date that the requirement or restriction was listed on the website of the health care plan or a contracted utilization review organization.

3. The date that the requirement or restriction was removed in this state.

4. A method to access a standardized electronic prior authorization request transaction process.

(4) Any clinical review criteria on which a prior authorization requirement or restriction is based shall satisfy all of the following:

(a) The criteria are based on nationally recognized, generally accepted standards except where provided by law.

(b) The criteria are developed in accordance with the current standards of a national medical accreditation entity.

(c) The criteria ensure quality of care and access to needed health care services.

(d) The criteria are evidence-based.

(e) The criteria are sufficiently flexible to allow deviations from current standards when justified.

(f) The criteria are evaluated and updated when necessary and no less frequently than once every year.

(5) No health care plan may deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date that the service was provided.

(6) No health care plan nor any utilization review organization contracted with a health care plan may deem supplies or services as incidental or deny a claim for supplies or services if a provided health care service associated with the

supplies or services receives prior authorization or if a provided health care service associated with the supplies or services does not require prior authorization.

(7) If a health care plan intends to impose a new prior authorization requirement or restriction or intends to amend a prior authorization requirement or restriction, the health care plan shall provide all providers contracted with the health care plan advanced written notice of the new or amended requirement or restriction no less than 60 days before the new or amended requirement or restriction is implemented. The advanced written notice may be provided in an electronic format if the provider has agreed in advance to receive the notices electronically. No health care plan may implement a new or amended prior authorization requirement or restriction unless the health care plan or a contracted utilization review organization has updated the post on its website required under sub. (3) to reflect the new or amended prior authorization requirement or restriction.

SECTION 219. 628.495 of the statutes is created to read:

628.495 Pharmacy benefit management broker and consultant licenses. (1) DEFINITION. In this section, "pharmacy benefit manager" has the meaning given in s. 632.865 (1) (c).

(2) LICENSE REQUIRED. Beginning on the first day of the 12th month beginning after the effective date of this subsection .... [LRB inserts date], no individual may act as a pharmacy benefit management broker or consultant and no individual may act to procure the services of a pharmacy benefit manager on behalf of a client without being licensed by the commissioner under this section.

(3) RULES. The commissioner may promulgate rules to establish criteria and

procedures for initial licensure and renewal of licensure and to implement licensure under this section.

SECTION 220. 632.728 of the statutes is created to read:

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

(a) "Cost sharing" includes deductibles, coinsurance, copayments, or similar charges.

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

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

(2) GUARANTEED ISSUE. (a) Every individual health benefit plan shall accept every individual in this state who, and every group health benefit plan shall accept every employer in this state that, applies for coverage, regardless of the sexual orientation, the gender identity, or any preexisting condition of any individual or employee who will be covered by the plan. A health benefit plan may restrict enrollment in coverage described in this paragraph to open or special enrollment periods.

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

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

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

1. Health status.

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

3. Claims experience.

4. Receipt of health care.

5. Medical history.

6. Genetic information.

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

8. Disability.

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

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

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

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

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

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

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

(5) STATEWIDE RISK POOL. An insurer offering a health benefit plan may not segregate enrollees into risk pools other than a single statewide risk pool for the individual market and a single statewide risk pool for the small employer market or a single statewide risk pool that combines the individual and small employer markets.

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

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

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

(7) COST SHARING MAXIMUM. A health benefit plan offered on the individual or small employer market may not require an enrollee under the plan to pay more in

cost sharing than the maximum amount calculated under 42 USC 18022 (c), including the annual indexing of the limits.

(8) MEDICAL LOSS RATIO. (a) In this subsection, "medical loss ratio" means the proportion, expressed as a percentage, of premium revenues spent by a health benefit plan on clinical services and quality improvement.

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

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

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

SECTION 221. 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 222. 632.746 (1) (b) of the statutes is repealed.

SECTION 223. 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 224. 632.746 (2) (c), (d) and (e) of the statutes are repealed.

SECTION 225. 632.746 (3) (a) of the statutes is repealed.

SECTION 226. 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

SECTION 227. 632.746 (3) (d) 2. and 3. of the statutes are repealed.

SECTION 228. 632.746 (5) of the statutes is repealed.

SECTION 229. 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 230. 632.748 (2) of the statutes is amended to read:

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

SECTION 231. 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 232. 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 233. 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).

(2) GUARANTEED ISSUE. An insurer that offers a short-term, limited duration plan shall accept every individual in this state who applies for coverage regardless of whether the individual has a preexisting condition.

(3) PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS. (a) An insurer that offers 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 a short-term, limited duration plan based on any of the following health status-related factors with respect 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 that offers a short-term, limited duration plan may not require any individual, as a condition of enrollment or continued enrollment under the short-term, limited duration plan, to pay, on the basis of any health status-related factor described 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 short-term, limited duration plan.

(4) PREMIUM RATE VARIATION. An insurer that offers a short-term, limited duration plan may vary premium rates for a specific short-term, limited duration plan based only on the following considerations:

(a) Whether the short-term, limited duration 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 short-term, limited duration plan.

(b) Limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the short-term, limited duration plan for a term of coverage or for the aggregate duration of the short-term, limited duration plan.

SECTION 234. 632.7498 of the statutes is created to read:

632.7498 Special enrollment period for pregnancy. (1) DEFINITIONS. In this section:

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

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

(2) SPECIAL ENROLLMENT PERIOD. A health benefit plan or self-insured health plan shall allow a pregnant individual who is eligible for coverage under the plan, and any individual who is eligible for coverage under the plan because of a relationship to the pregnant individual, to enroll for coverage at any time during the pregnancy. The coverage shall begin no later than the first day of the first calendar month in which the pregnant individual receives medical verification of the pregnancy, except that a pregnant individual may direct coverage to begin on the first day of any month occurring during the pregnancy.

(3) NOTICE. An insurer offering group health insurance coverage in this state shall provide notice of the special enrollment period under sub. (2) at or before the time an individual is initially offered the opportunity to enroll for coverage under the plan.

SECTION 235. 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a group health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance policy, as defined in s. 632.895 (1) (a), or a self-insured health plan, as defined in s. 632.85 (1) (c).

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

2. ~~Except as provided in subd. 3., an~~ An individual disability insurance policy, as defined in s. 632.895 (1) (a), other than a short-term ~~policy~~ limited duration plan subject to s. 632.7495 (4) and (5), may not define a preexisting condition more

restrictively than a condition that was present before the date of enrollment for the coverage, whether physical or mental, regardless of the cause of the condition, ~~for which~~ and regardless of whether medical advice, diagnosis, care, or treatment was recommended or received ~~within 12 months before the effective date of coverage~~.

SECTION 236. 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 ~~policy~~, limited duration plan subject to s. 632.7495 (4) and (5):

SECTION 237. 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 238. 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 239. 632.848 of the statutes is created to read:

632.848 Exemption from prior authorization requirements. (1) In this section:

(a) "Evaluation period" means the period of time established by the commissioner by rule that is used to evaluate whether a health care provider qualifies for an exemption from obtaining prior authorizations under sub. (2).

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

(c) "Health care item or service" includes all of the following:

1. Prescription drugs.

2. Laboratory testing.

3. Medical equipment.

4. Medical supplies.

(d) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (p).

(e) "Prior authorization" means a determination by a health benefit plan, self-insured health plans, or person contracting with a health benefit plan or self-insured health plan that health care items or services proposed to be provided to a patient are medically necessary and appropriate.

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

(2) The commissioner may by rule provide that any health benefit plan or self-

insured health plan that uses a prior authorization process shall exempt health care providers from obtaining prior authorizations for a health care item or service for a period of time established by the commissioner if, in the most recent evaluation period, the health benefit plan or self-insured health plan has approved or would have approved not less than the proportion of prior authorization requests established under sub. (3) submitted by the health care provider for the health care item or service.

(3) The commissioner shall specify the proportion of prior authorization requests submitted by a health care provider that have to be approved for the health care provider to qualify for an exemption from obtaining prior authorizations under sub. (2).

(4) The commissioner may specify by rule the health care items or services that may be subject to the exemption from obtaining prior authorizations under sub. (2).

(5) The commissioner may specify how health care providers may obtain an exemption from obtaining prior authorizations under sub. (2) including by providing a process for automatic evaluation.

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

SECTION 240. 632.851 of the statutes is created to read:

632.851 Reimbursement of emergency ambulance services. (1) In this section:

(a) "Ambulance service provider" has the meaning given in s. 256.01 (3).

(b) "Clean claim" means a claim that has no defect of impropriety, including a

lack of required substantiating documentation or any particular circumstance that requires special treatment that prevents timely payment from being made on the claim.

(c) "Emergency medical responder" has the meaning given in s. 256.01 (4p).

(d) "Emergency medical services practitioner" has the meaning given in s. 256.01 (5).

(e) "Firefighter" has the meaning given in s. 36.27 (3m) (a) 1m.

(f) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (hp).

(g) "Law enforcement officer" has the meaning given in s. 165.85 (2) (c).

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

(2) (a) A disability insurance policy or self-insured health plan shall, within 30 days after receipt of a clean claim for covered emergency ambulance services, promptly remit payment for the covered emergency ambulance services directly to the ambulance service provider. No disability insurance policy or self-insured health plan may send a payment for covered emergency ambulance services to an enrollee.

(b) A disability insurance policy or self-insured health plan shall respond to a claim for covered emergency ambulance services that is not a clean claim by sending a written notice, within 30 days after receipt of the claim, acknowledging the date of receipt of the claim and informing the ambulance service provider of one of the following:

1. That the disability insurance policy or self-insured health plan is declining to pay all or part of the claim, including the specific reason or reasons for the denial.

2. That additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is required.

(3) A disability insurance policy or self-insured health plan shall remit payment for the transportation of any patient by ambulance as a medically necessary emergency ambulance service if the transportation was requested by an emergency medical services practitioner, an emergency medical responder, a firefighter, a law enforcement officer, or a health care provider.

SECTION 241. 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 self-insured health plan or authorization from a physician to obtain the prescription drug under the disability insurance policy or self-insured health 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" means a self-insured health plan of the state or a county, city, village, town, or school district.

(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 amount and to any deductible of the disability insurance policy or self-insured health 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 the enrollee for that brand name drug.

SECTION 242. 632.863 of the statutes is created to read:

632.863 Pharmaceutical representatives. (1) DEFINITIONS. In this section:

(a) "Health care professional" means a physician or other health care practitioner who is licensed to provide health care services or to prescribe pharmaceutical or biologic products.

(b) "Pharmaceutical" means a medication that may legally be dispensed only with a valid prescription from a health care professional.

(c) "Pharmaceutical representative" means an individual who markets or promotes pharmaceuticals to health care professionals on behalf of a pharmaceutical manufacturer for compensation.

(2) LICENSURE. Beginning on the first day of the 12th month beginning after the effective date of this subsection .... [LRB inserts date], no individual may act as a pharmaceutical representative in this state without being licensed by the commissioner as a pharmaceutical representative under this subsection. In order to obtain a license under this subsection, the individual shall apply to the commissioner in the form and manner prescribed by the commissioner and shall

pay the fee under s. 601.31 (1) (nv). The term of a license issued under this subsection is one year, and the license is renewable.

(3) DISPLAY OF LICENSE. A pharmaceutical representative licensed under sub. (2) shall display the pharmaceutical representative's license during each visit with a health care professional.

(4) ENFORCEMENT. (a) Any individual who violates this section or any rules promulgated under this section shall be fined not less than $1,000 nor more than $3,000 for each offense. Each day of continued violation constitutes a separate offense.

(b) The commissioner may suspend or revoke the license of a pharmaceutical representative who violates this section or any rules promulgated under this section. A suspended or revoked license under this paragraph may not be reinstated until the pharmaceutical representative remedies all violations related to the suspension or revocation and pays all assessed penalties and fees.

(5) RULES. The commissioner shall promulgate rules to implement this section, including rules that require pharmaceutical representatives to complete continuing educational coursework as a condition of licensure.

SECTION 243. 632.864 of the statutes is created to read:

632.864 Pharmacy services administrative organizations. **(1)** DEFINITIONS. In this section:

(a) "Administrative service" means any of the following:

1. Assisting with claims.

2. Assisting with audits.

3. Providing centralized payment.

4. Performing certification in a specialized care program.

5. Providing compliance support.

6. Setting flat fees for generic drugs.

7. Assisting with store layout.

8. Managing inventory.

9. Providing marketing support.

10. Providing management and analysis of payment and drug dispensing data.

11. Providing resources for retail cash cards.

(b) "Independent pharmacy" means a pharmacy operating in this state that is licensed under s. 450.06 or 450.065 and is under common ownership with no more than 2 other pharmacies.

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

(d) "Pharmacy services administrative organization" means an entity operating in this state that does all of the following:

1. Contracts with an independent pharmacy to conduct business with a 3rd-party payer on the independent pharmacy's behalf.

2. Provides at least one administrative service to an independent pharmacy and negotiates and enters into a contract with a 3rd-party payer or pharmacy benefit manager on behalf of the independent pharmacy.

(e) "Third-party payer" means an entity, including a plan sponsor, health

maintenance organization, or insurer, operating in this state that pays or insures health, medical, or prescription drug expenses on behalf of beneficiaries.

(2) LICENSURE. (a) Beginning on the first day of the 12th month beginning after the effective date of this paragraph .... [LRB inserts date], no person may operate as a pharmacy services administrative organization without being licensed by the commissioner as a pharmacy services administrative organization under this subsection. In order to obtain a license under this paragraph, the person shall apply to the commissioner in the form and manner prescribed by the commissioner. The application for licensure under this paragraph shall include all of the following:

1. The name, address, telephone number, and federal employer identification number of the applicant.

2. The name, business address, and telephone number of a contact person for the applicant.

3. The fee under s. 601.31 (1) (nw).

4. Evidence of financial responsibility of at least $1,000,000.

5. Any other information required by the commissioner.

(b) The term of a license issued under par. (a) shall be 2 years from the date of issuance.

(c) A license issued under par. (a) may be renewed. Renewal applications shall be submitted to the commissioner on a form provided by the commissioner and shall include all the items described in par. (a) 1. to 5. A renewal application under this paragraph may not be submitted more than 90 days prior to the end of the term of the license being renewed.

(3) DISCLOSURE TO THE COMMISSIONER. (a) A pharmacy services administrative organization licensed under sub. (2) shall disclose to the commissioner the extent of any ownership or control of the pharmacy services administrative organization by an entity that does any of the following:

1. Provides pharmacy services.

2. Provides prescription drug or device services.

3. Manufactures, sells, or distributes prescription drugs, biologicals, or medical devices.

(b) A pharmacy services administrative organization licensed under sub. (2) shall notify the commissioner in writing within 5 days of any material change in its ownership or control relating to an entity described in par. (a).

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

SECTION 244. 632.865 (2m) of the statutes is created to read:

632.865 **(2m)** FIDUCIARY DUTY AND DISCLOSURES TO HEALTH BENEFIT PLAN SPONSORS. (a) A pharmacy benefit manager owes a fiduciary duty to the health benefit plan sponsor to act according to the health benefit plan sponsor's instructions and in the best interests of the health benefit plan sponsor.

(b) A pharmacy benefit manager shall annually provide, no later than the date and using the method prescribed by the commissioner by rule, the health benefit plan sponsor all of the following information from the previous calendar year:

1. The indirect profit received by the pharmacy benefit manager from owning any interest in a pharmacy or service provider.

2. Any payment made by the pharmacy benefit manager to a consultant or broker who works on behalf of the health benefit plan sponsor.

3. From the amounts received from all drug manufacturers, the amounts retained by the pharmacy benefit manager, and not passed through to the health benefit plan sponsor, that are related to the health benefit plan sponsor's claims or bona fide service fees.

4. The amounts, including pharmacy access and audit recovery fees, received from all pharmacies that are in the pharmacy benefit manager's network or have a contract to be in the network and, from these amounts, the amount retained by the pharmacy benefit manager and not passed through to the health benefit plan sponsor.

SECTION 245. 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, 2026, 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, 2026, 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 patient assistance program, the manufacturer shall do all of the following:

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

4. Maintain the privacy of all information received from an individual applying for or participating in the patient assistance 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 that established the patient assistance program, the individual's health care practitioner if the practitioner participates in the patient assistance 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 under 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, email 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 that 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 website 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 website 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 that 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 website 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 patient assistance 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, 2028, 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 violates this section may be required to forfeit not more than $200,000 per month of violation, with the maximum forfeiture

increasing to $400,000 per month if the manufacturer continues to be in violation after 6 months and increasing to $600,000 per month if the manufacturer continues to be in violation after one year.

SECTION 246. 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) No person, including a pharmacy benefit manager or 3rd-party payer, may 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 have a similar prescription volume to that of 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.

(3) The commissioner may promulgate rules to implement this section and to

establish minimum reimbursement rates for covered entities and any other entity described under 42 USC 256b (a) (4).

SECTION 247. 632.87 (1) of the statutes is amended to read:

632.87 **(1)** No insurer may refuse to provide or pay for benefits for health care services provided by a licensed health care professional on the ground that the services were not rendered by a physician as defined in s. 990.01 (28), unless the contract clearly excludes services by such practitioners, but no contract or plan may exclude services in violation of sub. (2), (2m), (3), (4), (4e), (4m), (5), or (6).

SECTION 248. 632.87 (4) of the statutes is amended to read:

632.87 **(4)** No policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed dentist ~~or dental therapist~~ within the scope of the dentist's ~~or dental therapist's~~ license, if the policy, plan or contract covers diagnosis and treatment of the condition or complaint by another health care provider, as defined in s. 146.81 (1) (a) to (p).

SECTION 249. 632.87 (4e) of the statutes is created to read:

632.87 **(4e)** In this subsection, "dental therapist" means an individual licensed under s. 447.04 (1m).

(b) No policy, plan, or contract may exclude coverage for dental services, treatments, or procedures provided by a dental therapist within the scope of the dental therapist's license if the policy, plan, or contract covers the dental services, treatments, or procedures when provided by another health care provider, as defined in s. 146.81 (1) (a) to (hp).

SECTION 250. 632.87 (7) of the statutes is created to read:

632.87 **(7)** (a) In this subsection:

1. "Health care provider" has the meaning given in s. 146.81 (1) (a) to (hp).

2. "Qualified treatment trainee" has the meaning given in s. DHS 35.03 (17m), Wis. Adm. Code.

(b) No policy, plan, or contract may exclude coverage for mental health or behavioral health treatment or services provided by a qualified treatment trainee within the scope of the qualified treatment trainee's education and training if the policy, plan, or contract covers the mental health or behavioral health treatment or services when provided by another health care provider.

SECTION 251. 632.87 (8) of the statutes is created to read:

632.87 **(8)** (a) In this subsection:

1. "Health care provider" has the meaning given in s. 146.81 (1) (a) to (hp).

2. "Substance abuse counselor" means a substance abuse counselor certified under s. 440.88.

(b) No policy, plan, or contract may exclude coverage for alcoholism or other drug abuse treatment or services provided by a substance abuse counselor within the scope of the substance abuse counselor's education and training if the policy, plan, or contract covers the alcoholism or other drug abuse treatment or services when provided by another health care provider.

SECTION 252. 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" means a self-insured health plan of the state or a county, city, village, town, or school district.

(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 email 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 disability insurance policy or self-insured health 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 disability insurance policy or self-insured health 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 253. 632.891 of the statutes is created to read:

632.891 Coverage without prior authorization for inpatient mental health services. A disability insurance policy, as defined in s. 632.895 (1) (a), or self-insured health plan, as defined in s. 632.745 (24), that covers inpatient mental health services may not require prior authorization for the provision or coverage of those services.

SECTION 254. 632.895 (6) (title) of the statutes is amended to read:

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

SECTION 255. 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 256. 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 disability insurance policy or self-insured health 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 covers insulin and imposes cost sharing on prescription drugs may not impose cost sharing on insulin in an amount that exceeds $35 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 257. 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 258. 632.895 (13m) of the statutes is created to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. Obesity screening and management for all minors and adults with a body mass index indicating obesity, counseling and behavioral interventions for obese

minors who are 6 years of age or older, and referral for intervention for obesity for adults with a body mass index of 30 kilograms per square meter or higher.

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

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

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

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

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

24. Gonorrhea prophylaxis treatment for newborns.

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

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

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

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

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

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

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

32. Screening for critical congenital health defects for newborns.

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

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

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

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

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

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

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

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

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

42. Developmental screening and surveillance for minors including newborns.

43. Psychosocial and behavioral assessment for minors including newborns.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Subject to par. (d), no disability insurance policy, except any disability insurance policy that is described in s. 632.745 (11) (b) 1. to 12., and no self-insured health plan may subject the coverage of any of the preventive services under par. (b) to any deductibles, copayments, or coinsurance under the policy or plan.

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

2. If the primary reason for an office visit is not to obtain a preventive service

specified under par. (b), the disability insurance policy or self-insured health plan may apply deductibles to and impose copayments or coinsurance on the office visit.

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

4. If more than one well-woman visit described under par. (b) 47. is necessary to provide all necessary preventive services as determined by a qualified health care provider and in accordance with applicable recommendations for preventive services, the disability insurance policy or self-insured health plan may not apply a deductible to or impose a copayment or coinsurance on any such well-woman visit.

SECTION 259. 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 260. 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 261. 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 262. 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 263. 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 264. 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 265. 632.895 (15m) of the statutes is created to read:

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

1. "Diagnosis of and treatment for infertility" means any recommended

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

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

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

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

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

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

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

surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

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

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

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

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

c. Impose any exclusion, limitation, cost-sharing requirement, benefit maximum, waiting period, or other restriction on coverage that is required under par. (b) of diagnosis of and treatment for infertility and standard fertility preservation services that is different from an exclusion, limitation, cost-sharing

requirement, benefit maximum, waiting period, or other restriction imposed on benefits for services that are covered by the policy or plan and that are not related to infertility.

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

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

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

SECTION 266. 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 267. 632.895 (17) (b) 1m. of the statutes is created to read:

632.895 **(17)** (b) 1m. Oral contraceptives that are lawfully furnished over the counter without a prescription.

SECTION 268. 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 269. 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 270. 632.897 (11) (a) of the statutes is amended to read:

632.897 **(11)** (a) Notwithstanding subs. (2) to (10), the commissioner may promulgate rules establishing standards requiring insurers to provide continuation of coverage for any individual covered at any time under a group policy who is a terminated insured or an eligible individual under any federal program that provides for a federal premium subsidy for individuals covered under continuation of coverage under a group policy, including rules governing election or extension of election periods, notice, rates, premiums, premium payment, ~~application of preexisting condition exclusions,~~ election of alternative coverage, and status as an eligible individual, as defined in s. 149.10 (2t), 2011 stats.

SECTION 9123. Nonstatutory provisions; Insurance.

(1) PRESCRIPTION DRUG PURCHASING ENTITY. During the 2025-27 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.

(2) STAGGERED TERMS FOR PRESCRIPTION DRUG AFFORDABILITY REVIEW BOARD. Notwithstanding the length of terms specified for the members of the prescription drug affordability review board under s. 15.735 (1) (b) to (e), 2 of the initial members shall be appointed for terms expiring on May 1, 2027; 2 of the initial members shall be appointed for terms expiring on May 1, 2028; 2 of the initial members shall be appointed for terms expiring on May 1, 2029; and 2 of the initial members shall be appointed for terms expiring on May 1, 2030.

(3) 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).

(4) PUBLIC OPTION HEALTH INSURANCE PLAN. From the appropriation under s. 20.145 (1) (g), the office of the commissioner of insurance may expend not more than $500,000 in fiscal year 2025-26 and not more than $500,000 in fiscal year 2026-27 for the development of a public option health insurance plan.

(5) FUNDING FOR HEALTH INSURANCE NAVIGATORS.

(a) In this subsection:

1. "Commissioner" means the commissioner of insurance.

2. "Navigator" means an individual navigator licensed under s. 628.92 (1) or a navigator entity licensed under s. 628.92 (2).

(b) From the appropriation under s. 20.145 (1) (g), the commissioner shall award $500,000 in fiscal year 2025-26 and shall award $500,000 in fiscal year 2026-27 to a navigator to prioritize services for the direct care workforce population.

SECTION 9223. Fiscal changes; Insurance.

(1) HEALTH INSURANCE RISK-SHARING PLAN BALANCE TRANSFER. Any balance of moneys that was credited to the appropriation account under s. 20.145 (5) (g), 2013 stats., or s. 20.145 (5) (k), 2013 stats., and that was not lapsed as a result of

2015 Wisconsin Act 55 is transferred in fiscal year 2025-26 to the appropriation account under s. 20.145 (1) (g).

SECTION 9323. Initial applicability; Insurance.

(1) COVERAGE OF INFERTILITY SERVICES.

(a) For policies and plans containing provisions inconsistent with these sections, the treatment of ss. 609.74 and 632.895 (15m) first applies to policy or plan years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in pars. (b) and (c).

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

(c) For policies and plans that are affected by a collective bargaining agreement containing provisions inconsistent with these sections, the treatment of ss. 609.74 and 632.895 (15m) first applies to policy or plan years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.

(2) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES.

(a) For policies and plans containing provisions inconsistent with these sections, the treatment of ss. 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac)

1. and 2., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c), and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) first applies to policy or plan years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in par. (b).

(b) For policies and plans that are affected by a collective bargaining agreement containing provisions inconsistent with these sections, the treatment of ss. 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1. and 2., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c), and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) first applies to policy or plan years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.

(3) COVERAGE OF OVER-THE-COUNTER ORAL CONTRACEPTIVES.

(a) For policies and plans containing provisions inconsistent with s. 632.895 (17) (b) 1m., the treatment of s. 632.895 (17) (b) 1m. 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. 632.895 (17) (b) 1m., the treatment of s. 632.895 (17) (b) 1m. 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.

(4) QUALIFIED TREATMENT TRAINEE COVERAGE.

(a) For policies and plans containing provisions inconsistent with ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, and 632.87 (7), the treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, and 632.87 (7) 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 ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, and 632.87 (7), the treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, and 632.87 (7) 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.

(5) DENTAL THERAPIST COVERAGE.

(a) For policies and plans containing provisions inconsistent with ss. 609.718 and 632.87 (1), (4), and (4e), the treatment of ss. 609.718 and 632.87 (1), (4), and (4e) 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 ss. 609.718 and 632.87 (1), (4), and (4e), the treatment of ss. 609.718 and 632.87 (1), (4), and (4e) 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.

(6) APPLICATION OF MANUFACTURER DISCOUNTS.

(a) For policies and plans containing provisions inconsistent with the treatment of s. 609.83, the treatment of s. 609.83 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. 609.83, the treatment of s. 609.83 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.

(7) 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.

(8) SUBSTANCE ABUSE COUNSELOR COVERAGE.

(a) For policies and plans containing provisions inconsistent with the treatment of ss. 609.714 and 632.87 (8), the treatment of ss. 609.714 and 632.87 (8)

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 the treatment of ss. 609.714 and 632.87 (8), the treatment of ss. 609.714 and 632.87 (8) 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.

(9) 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 the treatment of 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.

(10) COVERAGE OF EMERGENCY AMBULANCE SERVICES.

(a) For policies and plans containing provisions inconsistent with ss. 609.825 and 632.851, the treatment of ss. 609.825 and 632.851 first applies to policy or plan years beginning on the effective date of this paragraph, except as provided in par. (b).

(b) For policies and plans that are affected by a collective bargaining

agreement containing provisions inconsistent with ss. 609.825 and 632.851, the treatment of ss. 609.825 and 632.851 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.

(11) INPATIENT MENTAL HEALTH PRIOR AUTHORIZATION.

(a) For policies and plans containing provisions inconsistent with ss. 609.823 and 632.891, the treatment of ss. 609.823 and 632.891 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 ss. 609.823 and 632.891, the treatment of ss. 609.823 and 632.891 first applies to policy or plan years beginning on the effective date of this subsection or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

(12) SPECIAL ENROLLMENT PERIOD FOR PREGNANCY.

(a) For policies and plans containing provisions inconsistent with ss. 609.40 and 632.7498, the treatment of ss. 609.40 and 632.7498 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 ss. 609.40 and 632.7498, the treatment of ss. 609.40 and 632.7498 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.

SECTION 9423. Effective dates; Insurance.

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

(2) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES. The treatment of ss. 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1. and 2., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c), and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) and SECTION 9323 (2) of this act take effect on the first day of the 4th month beginning after publication.

(3) COVERAGE OF OVER-THE-COUNTER ORAL CONTRACEPTIVES. The treatment of s. 632.895 (17) (b) 1m. and SECTION 9323 (3) of this act take effect on the first day of the 4th month beginning after publication.

(4) QUALIFIED TREATMENT TRAINEE COVERAGE. The treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, and 632.87 (7) and SECTION 9323 (4) of this act take effect on the first day of the 4th month beginning after publication.

(5) DENTAL THERAPIST COVERAGE. The treatment of ss. 609.718 and 632.87 (1), (4), and (4e) and SECTION 9323 (5) of this act take effect on the first day of the 4th month beginning after publication.

(6) COST-SHARING CAP ON INSULIN. The treatment of ss. 609.83 and 632.895 (6) (title), the renumbering and amendment of s. 632.895 (6), and the creation of s. 632.895 (6) (b) and SECTION 9323 (6) take effect on the first day of the 4th month beginning after publication.

(7) APPLICATION OF MANUFACTURER DISCOUNTS. The treatment of s. 632.862 and SECTION 9323 (7) take effect on the first day of the 4th month beginning after publication.

(8) SUBSTANCE ABUSE COUNSELOR COVERAGE. The treatment of ss. 609.714 and 632.87 (8) and SECTION 9323 (8) of this act take effect on the first day of the 4th month beginning after publication.

(9) 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 ch. 601 and SECTION 9123 (2) of this act take effect on the first day of the 7th month beginning after publication.

(10) COVERAGE OF EMERGENCY AMBULANCE SERVICES. The treatment of ss. 609.825 and 632.851 and SECTION 9323 (10) of this act take effect on the first day of the 4th month beginning after publication.

(11) INPATIENT MENTAL HEALTH PRIOR AUTHORIZATION. The treatment of ss. 609.823 and 632.891 and SECTION 9323 (11) of this act take effect on the first day of the 4th month beginning after publication.

(12) SPECIAL ENROLLMENT PERIOD FOR PREGNANCY. The treatment of ss. 609.40 and 632.7498 takes effect on the first day of the 4th month beginning after publication.".

3. At the appropriate places, insert all of the following:

"**SECTION 1.** 250.15 (1) (c) of the statutes is created to read:

250.15 **(1)** (c) "Health center look-alike" means a health care entity that is designated by the federal health resources and services administration as a federally qualified health center look-alike.

SECTION 2. 250.15 (2) (bm) of the statutes is created to read:

250.15 (2) (bm) To community health centers, $800,000.

SECTION 3. 250.15 (2) (d) of the statutes is amended to read:

250.15 **(2)** (d) ~~Two million two hundred fifty thousand~~ Three million dollars to free and charitable clinics.

SECTION 4. 250.15 (2) (e) of the statutes is created to read:

250.15 **(2)** (e) To health center look-alikes, $200,000. A grant awarded to a health center look-alike under this paragraph may not exceed $100,000.

SECTION 9219. Fiscal changes; Health Services.

(1) GRANTS FOR COMMUNITY HEALTH CENTERS. In the schedule under s. 20.005 (3) for the appropriation to the department of health services under s. 20.435 (1) (fh), the dollar amount for fiscal year 2025-26 is increased by $1,750,000 to pay for grants to community health centers under s. 250.15 (2) (bm), grants to free and charitable clinics under s. 250.15 (2) (d), and grants to health center look-alikes under s. 250.15 (2) (e). In the schedule under s. 20.005 (3) for the appropriation to the department of health services under s. 20.435 (1) (fh), the dollar amount for fiscal year 2026-27 is increased by $1,750,000 to pay for grants to community health centers under s. 250.15 (2) (bm), grants to free and charitable clinics under s. 250.15 (2) (d), and grants to health center look-alikes under s. 250.15 (2) (e).".

4. At the appropriate places, insert all of the following:

"**SECTION 271.** 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 day or, if approved by the federal government, the ~~90th~~ 365th day after the last day of the pregnancy falls.

SECTION 272. 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 day or, if approved by the federal government, the ~~90th~~ 365th day after the last day of the pregnancy falls without regard to any change in the individual's family income.

SECTION 273. 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 day or, if approved by the federal government, the ~~90th~~ 365th day after the last day of the pregnancy falls.

SECTION 274. 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 day or, if approved by

the federal government, the ~~90th~~ 365th day after the last day of the pregnancy falls without regard to any change in the woman's family income.

SECTION 275. 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 day or, if approved by the federal government, the ~~90th~~ 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.".

5. At the appropriate places, insert all of the following:

"**SECTION 276.** 46.48 (10) of the statutes is created to read:

46.48 **(10)** HOSPITAL SERVICES GRANTS. (a) The department shall distribute grants to eligible hospitals approved by the department of health services located in the western public health region of the state, as determined by the department of health services, to support creation of new or enhanced hospital department services targeted to alleviating hospital access challenges in the Chippewa Valley region following the hospital closures in Chippewa Falls and Eau Claire.

(b) A hospital is eligible for a grant under this subsection if it has either applied for, or possesses, approval of the department of health services as a hospital under ch. DHS 124, Wis. Adm. Code, at the time of grant award.".

(END)