State of Wisconsin
2007 – 2008 LEGISLATURE

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SENATE AMENDMENT 2,

TO SENATE SUBSTITUTE AMENDMENT 1,

TO 2007 SENATE BILL 40

June 26, 2007 – Offered by Senator ROBSON.

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

1. Page 317, line 9: after "Biennially," insert "from the conservation fund,".

2. Page 467, line 8: after that line insert:

"**SECTION 733mr.** 36.27 (3n) (b) 2. of the statutes is amended to read:

36.27 **(3n)** (b) 2. ~~An~~ Except as provided in subd. 2m., an unremarried surviving spouse of an eligible veteran. The remission under this subdivision applies only during the first 10 years after the veteran died.

SECTION 733mw. 36.27 (3n) (b) 2m. of the statutes is created to read:

36.27 **(3n)** (b) 2m. An unremarried surviving spouse of an eligible veteran who had a child with the eligible veteran. The remission under this subdivision applies only until 10 years after the youngest child that the spouse had with the eligible

veteran reaches or would have reached 18 years of age, or during the first 10 years after the veteran died, whichever is longer.".

3. Page 476, line 18: after that line insert:

"**SECTION 738mr.** 38.24 (7) (b) 2. of the statutes is amended to read:

38.24 **(7)** (b) 2. ~~An~~ Except as provided in subd. 2m., an unremarried surviving spouse of an eligible veteran. The remission under this subdivision applies only during the first 10 years after the veteran died.

SECTION 738mw. 38.24 (7) (b) 2m. of the statutes is created to read:

38.24 **(7)** (b) 2m. An unremarried surviving spouse of an eligible veteran who had a child with the eligible veteran. The remission under this subdivision applies only until 10 years after the youngest child that the spouse had with the eligible veteran reaches or would have reached 18 years of age, or during the first 10 years after the veteran died, whichever is longer.".

4. Page 485, line 17: after that line insert:

"**SECTION 770c.** 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), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.895 (5m) and (8) to ~~(14)~~ (15), and 632.896.

SECTION 770d. 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, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to ~~(14)~~ (15).".

5. Page 707, line 9: after that line insert:

"**SECTION 1545t.** 49.45 (22) of the statutes is renumbered 49.45 (22) (intro.) and amended to read:

49.45 **(22)** MEDICAL ASSISTANCE SERVICES PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS. (intro.) If the department contracts with health maintenance organizations for the provision of medical assistance it shall ~~give~~ do all of the following:

(a) Give special consideration to health maintenance organizations that provide or that contract to provide comprehensive, specialized health care services to pregnant teenagers. ~~If the department contracts with health maintenance organizations for the provision of medical assistance, the department shall determine~~

(b) Determine which medical assistance recipients who have attained the age of 2 but have not attained the age of 6 and who are at risk for lead poisoning have not received lead screening from those health maintenance organizations~~. The department shall~~ and report annually to the appropriate standing committees of the legislature under s. 13.172 (3) on the percentage of medical assistance recipients under the age of 2 who received a lead screening test in that year provided by a health maintenance organization compared with the percentage that the department set as a goal for that year.

SECTION 1545u. 49.45 (22) (c) of the statutes is created to read:

49.45 **(22)** (c) 1. Calculate that portion of any increase in the capitation rate paid to each health maintenance organization under this subsection after the effective date of this paragraph .... [revisor inserts date], if the increase is made to reflect increases in fee–for–service medical assistance payment rates to one or more class of providers.

2. Require each health maintenance organization to increase its payments to any class of providers for services to medical assistance recipients in amounts that the department determines are consistent with both the purpose and intent of the fee–for–service rate increase and the objective of reducing unnecessary utilization through managed care, and to amend its contracts with service providers correspondingly.

3. Conduct audits to ensure that health maintenance organizations comply with the requirement of this paragraph.".

6. Page 832, line 17: after that line insert:

"**SECTION 1874c.** 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), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.895 (9) to ~~(14)~~ (15), 632.896, and 767.513 (4).".

7. Page 1228, line 17: after that line insert:

"**SECTION 2680c.** 111.91 (2) (n) of the statutes is amended to read:

111.91 **(2)** (n) The provision to employees of the health insurance coverage required under s. 632.895 (11) to ~~(14)~~ (15).".

8. Page 1241, line 22: after that line insert:

"**SECTION 2737p.** 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), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),

632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.895 (9) to ~~(14)~~ (15), 632.896, and 767.513 (4).".

9. Page 1274, line 9: after that line insert:

"**SECTION 2924c.** 185.981 (4t) of the statutes is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (10) to ~~(14)~~ (15), and 632.897 (10) and chs. 149 and 155.

SECTION 2924f. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan 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, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (5) and (9) to ~~(14)~~ (15), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:".

10. Page 1497, line 21: after that line insert:

"**SECTION 3660c.** 609.87 of the statutes is created to read:

609.87 Coverage of treatment for autism spectrum disorders. Defined network plans are subject to s. 632.895 (15).".

11. Page 1504, line 2: after that line insert:

"**SECTION 3677c.** 632.726 of the statutes is created to read:

632.726 Current procedural terminology code changes. (1) In this section, "current procedural terminology code" means a number established by the

American Medical Association that a health care provider puts on a health insurance claim form to describe the services that he or she performed.

(2) If an insurer changes a current procedural terminology code that was submitted by a health care provider on a health insurance claim form, the insurer shall include on the explanation of benefits form the reason for the change to the current procedural terminology code and shall cite on the explanation of benefits form the source for the change.".

12. Page 1504, line 8: after that line insert:

"**SECTION 3680f.** 632.857 of the statutes is created to read:

632.857 Explanation required for restriction or termination of coverage. If an insurer restricts or terminates an insured's coverage for the treatment of a condition or complaint and, as a result, the insured becomes liable for payment for all of his or her treatment for the condition or complaint, the insurer shall provide on the explanation of benefits form a detailed explanation of the clinical rationale and of the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage.

SECTION 3681w. 632.875 (2) (g) of the statutes is amended to read:

632.875 **(2)** (g) A ~~reasonable~~ detailed explanation of the ~~factual basis~~ clinical rationale and of the basis in the policy, plan, or contract or in applicable law for the insurer's restriction or termination of coverage.

SECTION 3682b. 632.89 (1) (am) of the statutes is created to read:

632.89 **(1)** (am) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

SECTION 3683b. 632.89 (2) (b) 1. of the statutes is amended to read:

632.89 **(2)** (b) 1. Except as provided in subd. 2., if a group or blanket disability insurance policy issued by an insurer provides coverage of inpatient hospital treatment or outpatient treatment or both, the policy shall provide coverage in every policy year as provided in pars. (c) to (dm), as appropriate, except that the total coverage under the policy for a policy year need not exceed ~~$7,000~~ $20,250 or the equivalent benefits measured in services rendered.

SECTION 3684b. 632.89 (2) (c) 2. b. of the statutes is amended to read:

632.89 **(2)** (c) 2. b. ~~Seven thousand~~ Twenty thousand two hundred fifty dollars minus any applicable cost sharing at the level charged under the policy for inpatient hospital services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$6,300~~ $18,250 in equivalent benefits measured in services rendered.

SECTION 3685b. 632.89 (2) (d) 2. of the statutes is amended to read:

632.89 **(2)** (d) 2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than ~~$2,000~~ $3,450 minus any applicable cost sharing at the level charged under the policy for outpatient services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$1,800~~ $3,100 in equivalent benefits measured in services rendered.

SECTION 3686b. 632.89 (2) (dm) 2. of the statutes is amended to read:

632.89 **(2)** (dm) 2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than ~~$3,000~~ $5,200 minus any applicable cost sharing at the level charged under the policy for transitional treatment arrangements or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$2,700~~ $4,650 in equivalent benefits measured in services rendered.

SECTION 3687b. 632.89 (2) (f) of the statutes is created to read:

632.89 **(2)** (f) *Report on coverage limits.* The department of health and family services shall report annually to the governor and the legislature on revising the coverage limits specified in this subsection based on the change in the consumer price index for medical costs.

SECTION 3687r. 632.895 (15) of the statutes is created to read:

632.895 **(15)** TREATMENT FOR AUTISM SPECTRUM DISORDERS. (a) In this subsection, "autism spectrum disorder" means any of the following:

1. Autism disorder.

2. Asperger's syndrome.

3. Pervasive developmental disorder not otherwise specified.

(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, shall provide coverage for an insured of treatment for an autism spectrum disorder if the treatment is provided by any of the following:

1. A psychiatrist, as defined in s. 146.34 (1) (h).

2. A person who practices psychology, as described in s. 455.01 (5).

3. A social worker, as defined in s. 252.15 (1) (er), who is certified or licensed to practice psychotherapy, as defined in s. 457.01 (8m).

4. A speech–language pathologist, as defined in s. 459.20 (4).

5. A paraprofessional working under the supervision of a provider listed under subds. 1. to 4.

6. A professional working under the supervision of an outpatient mental health clinic certified under s. 51.038.

(c) The coverage required under par. (b) may be subject to any limitations, exclusions, and cost–sharing provisions that apply generally under the disability insurance policy or self–insured health plan.

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

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

3. A long–term care insurance policy.

4. A medicare replacement policy or a medicare supplement policy.".

13. Page 1646, line 25: delete "$20,000,000" and substitute "$27,000,000".

14. Page 1658, line 16: after that line insert:

"(9f) MEDICAL ASSISTANCE PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS. The the renumbering and amendment of section 49.45 (22) of the statutes and the creation of 49.45 933) (c) of the statutes first applies to contracts in existence on the effective date of this subsection.".

15. Page 1659, line 3: after that line insert:

"(1f) HEALTH INSURANCE; TREATMENT RESTRICTION OR TERMINATION; CLAIM FORMS.

(d) Except as provided in paragraph (b), the treatment of sections 632.726, 632.857, and 632.875 (2) (g) of the statutes first applies to claims for insurance coverage that are submitted to an insurer on the effective date of this paragraph.

(e) If a health insurance policy or plan that is in effect on the effective date of this paragraph contains a provision that is inconsistent with the treatment of section 632.726, 632.857, or 632.875 (2) (g) of the statutes, the treatment of section 632.726,

632.857, or 632.875 (2) (g) of the statutes, whichever is applicable, first applies to that health insurance policy or plan on the date on which it is renewed.

(2f) LIMITS FOR MENTAL HEALTH AND DRUG ABUSE COVERAGE. The treatment of section 632.89 (1) (am) and (2) (b) 1., (c) 2. b., (d) 2., (dm) 2., and (f) of the statutes first applies to a policy issued, renewed, or modified on the first day of the 13th month beginning after publication.

(2i) COVERAGE OF TREATMENT FOR AUTISM SPECTRUM DISORDERS. The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 111.91 (2) (n), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.87, and 632.895 (15) of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and self–insured governmental or school district health plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Self–insured governmental or school district health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.".

16. Page 1672, line 1: after that line insert:

"(2i) COVERAGE OF TREATMENT FOR AUTISM SPECTRUM DISORDERS. The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 111.91 (2) (n), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.87, and 632.895 (15) of the statutes and SECTION 9325 (1) of this act take effect on the first day of the 7th month beginning after publication.".

(END)