LRB−0660/1
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2007 ASSEMBLY BILL 16

January 12, 2007 − Introduced by Representative SCHNEIDER. Referred to Committee on Health and Healthcare Reform.

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 111.91 (2) (n), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 632.895 (15) of the statutes; **relating to:** requiring health insurance policies to cover orphan drugs and granting rule−making authority.

Analysis by the Legislative Reference Bureau

This bill requires health insurance policies and plans that cover prescription drugs to cover any drug that is prescribed for an insured by a physician for the treatment of a rare disease or condition. A rare disease or condition, which is defined in the bill by a cross−reference to federal law, is a disease or condition that: 1) affects fewer than 200,000 persons in the United States; or 2) affects 200,000 or more persons in the United States, but there is no reasonable expectation that the sale in the United States of a drug for the disease or condition will recover the cost of developing and making the drug available in the United States. The bill requires the commissioner of insurance to promulgate a rule that specifies the drugs to which the coverage requirement applies.

The coverage requirement applies to both individual and group health insurance policies and plans, including defined network plans and cooperative sickness care associations; to health care plans offered by the state to its employees, including a self−insured plan; and to self−insured health plans of counties, cities, towns, villages, and school districts. The requirement specifically does not apply to limited service health organizations or preferred provider plans that provide only limited−scope dental or vision benefits, medicare replacement or supplement

policies, or policies covering only certain specified diseases. The requirement may be subject to any limitations, exclusions, or cost−sharing provisions that apply generally under the policy or plan.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 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 2. 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).

SECTION 3. 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).

SECTION 4. 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).

SECTION 5. 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).

SECTION 6. 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 7. 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:

SECTION 8. 632.895 (15) of the statutes is created to read:

632.895 **(15)** DRUGS FOR THE TREATMENT OF RARE DISEASES. (a) In this subsection, "rare disease or condition" has the meaning given in 21 USC 360bb (a) (2).

(b) Except as provided in par. (e), every disability insurance policy, and every self−insured health plan of the state or a county, city, village, town, or school district, that provides coverage of prescription medication shall provide coverage for any drug that is specified by rule under par. (d) and that is prescribed for an individual covered

under the policy or plan by a physician for the treatment of a rare disease or condition.

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

(d) The commissioner shall by rule specify the prescription drugs to which the requirement under par. (b) applies.

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

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

2. A health care plan offered by a preferred provider plan, as defined in s. 609.01 (4), that provides only limited−scope dental or vision benefits, or by a limited service health organization, as defined in s. 609.01 (3).

3. A medicare replacement policy or a medicare supplement policy.

SECTION 9. Initial applicability.

(1) This act 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 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 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.

SECTION 10. Effective date.

(1) This act takes effect on the first day of the 13th month beginning after publication.

(END)