State of Wisconsin
2009 – 2010 LEGISLATURE

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# SENATE SUBSTITUTE AMENDMENT 1,

# TO 2009 SENATE BILL 3

February 6, 2009 – Offered by Senator ROBSON.

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*** 609.87 and 632.895 (16) of the statutes; **relating to:** health insurance coverage of autism treatment, providing an exemption from emergency rule procedures, and granting rule–making authority.

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***Analysis by the Legislative Reference Bureau***

This substitute amendment requires health insurance policies and self–insured governmental and school district health plans to cover the cost of treatment for an insured for autism, Asperger's syndrome, and pervasive developmental disorder not otherwise specified if the treatment is prescribed by a physician and provided by a psychiatrist, a psychologist, a social worker who is certified or licensed to practice psychotherapy, a paraprofessional working under the supervision of any of those three types of providers, a professional working under the supervision of an outpatient mental health clinic, a speech–language pathologist, or an occupational therapist. The providers must be qualified to provide the services. The coverage provided must be at least $60,000 for intensive–level services per year per insured, with a minimum of 30 to 35 hours of care per week for a minimum duration of four years, and at least $30,000 for post–intensive–level services per year per insured. Beginning in 2011, the minimum coverage monetary amounts will be

adjusted annually to reflect changes in the medical consumer price index. The commissioner of insurance will publish the new minimum amounts each year in the Wisconsin Administrative Register. The commissioner must also promulgate a rule that further defines "intensive–level services," "post–intensive–level services," "paraprofessional," and "qualified" for purposes of the coverage requirement and may promulgate rules for the requirement's interpretation or administration.

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–scope benefit plans, medicare replacement or supplement policies, long–term care policies, or policies covering only certain specified diseases.

The coverage may be subject to any deductibles, coinsurance, or copayments that apply generally under the policy or plan, but may not be subject to any limitations or exclusions, including limitations on the number of treatment visits.

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***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 ~~(5)~~ (6), 632.895 (5m) and (8) to ~~(15)~~ (16), 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 ~~(15)~~ (16).

**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), ~~and~~ (5)<u>, and (6)</u>, 632.895 (9) to ~~(15)~~ <u>(16)</u>, 632.896, and ~~767.25 (4m) (d)~~ <u>767.513 (4)</u>.

**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) <u>and (16)</u>.

**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) ~~and,~~ (5)<u>, and (6)</u>, 632.895 (9) to ~~(15)~~ <u>(16)</u>, 632.896, and ~~767.25 (4m) (d)~~ <u>767.513 (4)</u>.

**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), ~~and~~ (5)<u>, and (6)</u>, 632.895 (10) to ~~(15)~~ <u>(16)</u>, 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), ~~and~~ (5)<u>, and (6)</u>, 632.895 (5) and (9) to ~~(15)~~ <u>(16)</u>, 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

**SECTION 8.** 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 (16).

**SECTION 9.** 632.895 (16) of the statutes is created to read:

632.895 **(16)** TREATMENT FOR AUTISM SPECTRUM DISORDERS. (a) In this subsection:

1. "Autism spectrum disorder" means any of the following:

a. Autism disorder.

b. Asperger's syndrome.

c. Pervasive developmental disorder not otherwise specified.

2. "Insured" includes an enrollee and a dependent with coverage under the disability insurance policy or self–insured health plan.

3. "Intensive–level services" means evidence–based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder.

4. "Physician" has the meaning given in s. 146.34 (1) (g).

5. "Post–intensive–level services" means therapy that occurs after the completion of treatment with intensive–level services and that is designed to sustain and maximize gains made during treatment with intensive–level services or, for an individual who has not and will not receive intensive–level services, therapy that will improve the individual's condition.

(b) Subject to pars. (c) and (d), and except as provided in par. (e), 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 the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by any of the following who are qualified to provide intensive–level services or post–intensive–level services:

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 paraprofessional working under the supervision of a provider listed under subds. 1. to 3.

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

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

7. An occupational therapist, as defined in s. 448.96 (4).

(c) 1. The coverage required under par. (b) shall provide at least $60,000 for intensive–level services per insured per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years, and at least $30,000 for post–intensive–level services per insured per year, except that these minimum coverage monetary amounts shall be adjusted annually, beginning in 2011, to reflect changes 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. The commissioner shall publish the new minimum coverage amounts under this subdivision each year, beginning in 2011, in the Wisconsin Administrative Register.

2. Notwithstanding subd. 1., the minimum coverage monetary amounts or duration required for treatment under subd. 1., need not be met if it is determined by a supervising professional, in consultation with the insured's physician, that less treatment is medically appropriate.

(d) The coverage required under par. (b) may be subject to deductibles, coinsurance, or copayments that generally apply to other conditions covered under

the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

(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 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.

(f) 1. The commissioner shall by rule further define "intensive–level services" and "post–intensive–level services" and define "paraprofessional" for purposes of par. (b) 4. and "qualified" for purposes of providing services under this subsection. The commissioner may promulgate rules governing the interpretation or administration of this subsection.

2. Using the procedure under s. 227.24, the commissioner may promulgate the rules under subd. 1. for the period before the effective date of the permanent rules promulgated under subd. 1., but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subdivision 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 subdivision.

**SECTION 10. Initial applicability.**

(1) INSURANCE COVERAGE FOR AUTISM TREATMENT. 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 governmental or school district health plans that are established, extended, modified, or renewed, on the first day of the 5th month beginning after publication.

(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.

**(END)**