State of Wisconsin
2009 - 2010 LEGISLATURE

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2009 ASSEMBLY BILL 331

June 29, 2009 - Introduced by Representatives TOWNSEND, BERCEAU, NERISON, RICHARDS, SOLETSKI and TURNER, cosponsored by Senators HANSEN, TAYLOR and WIRCH. Referred to Committee on Insurance.

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 111.91 (2) (n), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.22 (1) and 609.22 (2); and ***to create*** 609.835 and 632.895 (16) of the statutes; **relating to:** insurance coverage of orthotic and prosthetic devices and services.

Analysis by the Legislative Reference Bureau

This bill requires a health care plan that covers hospital, medical, or surgical expenses to cover the cost of orthotic devices and prosthetic devices that are prescribed by a physician as medically necessary. Orthotic devices are defined under the bill, generally, as rigid or semirigid devices that are used to support, restrain, limit, correct, or enhance motion in a weak or deformed human body part. Prosthetic devices are defined as replacements for an external human body part in whole or in part. Besides covering the devices, a health care plan must cover services and supplies relating to the devices and the repair or replacement of the devices. Additionally, a defined network plan must ensure that covered orthotic and prosthetic services may be obtained from at least two different providers of orthotic devices and at least two different providers of prosthetic devices that are located within a reasonable travel distance or time, defined as 60 miles or less or 60 minutes or less. If a defined network plan does not have at least two different providers of orthotic devices and at least two different providers of prosthetic devices in its provider network, it must cover the services of a provider outside its network that is located within a reasonable travel distance or time, at no additional cost to an insured under the plan, to ensure that insureds under the plan have a choice of at

least two different providers of orthotic devices and at least two different providers of prosthetic devices.

The coverage requirement applies to both individual and group health insurance policies and plans, including health care plans offered by the state, a municipality, or a school district. The coverage may not be subject to any limitations, exclusions, or cost–sharing provisions that are greater than those 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 ~~(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), and (6), 632.895 (9) to ~~(15)~~ (16), 632.896, and ~~767.25 (4m) (d)~~ 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) and (16).

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), and (6), 632.895 (9) to ~~(15)~~ (16), 632.896, and ~~767.25 (4m) (d)~~ 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), ~~and~~ (5), and (6), 632.895 (10) to ~~(15)~~ (16), 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), and (6), 632.895 (5) and (9) to ~~(15)~~ (16), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 8. 609.22 (1) of the statutes is amended to read:

609.22 **(1)** PROVIDERS. ~~A~~ Subject to s. 632.895 (16) (c) 1. and 2., a defined network plan shall include a sufficient number, and sufficient types, of qualified providers to meet the anticipated needs of its enrollees, with respect to covered

benefits, as appropriate to the type of plan and consistent with normal practices and standards in the geographic area.

SECTION 9. 609.22 (2) of the statutes is amended to read:

609.22 **(2)** ADEQUATE CHOICE. A defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are accessible, subject to s. 632.895 (16) (c) 1. and 3., and qualified.

SECTION 10. 609.835 of the statutes is created to read:

609.835 Coverage of orthotic and prosthetic devices and services. Defined network plans are subject to s. 632.895 (16).

SECTION 11. 632.895 (16) of the statutes is created to read:

632.895 **(16)** COVERAGE OF ORTHOTIC AND PROSTHETIC DEVICES AND SERVICES. (a) In this subsection:

1. "Defined network plan" has the meaning given in s. 609.01 (1b).

2. "Human body part" includes a leg, a foot, an arm, a hand, the torso, the neck, and the head.

3. "Orthotic device" means a rigid or semirigid device used to support a weak or deformed human body part, or to restrain, limit, correct, or enhance motion in a diseased or injured human body part.

4. "Prosthetic device" means a replacement for an external human body part that is designed to replace the human body part in whole or in part.

5. "Self–insured health plan" has the meaning given in s. 632.745 (24).

(b) Every disability insurance policy, and every self–insured health plan, that provides coverage of hospital, medical, or surgical expenses shall provide coverage of all of the following:

1. Orthotic devices and prosthetic devices that are prescribed by a physician and determined by the prescribing physician to be medically necessary.

2. Services and supplies relating to an orthotic or prosthetic device that the prescribing physician determines to be medically necessary, including design, fabrication, material and component selection, measurements, fittings, static and dynamic alignment, device maintenance, and instruction of the wearer of the device in the use and care of the device.

3. The repair or replacement of an orthotic or prosthetic device that the prescribing physician determines to be medically necessary.

(c) 1. A defined network plan that is subject to this subsection shall ensure that the services for which coverage is required under par. (b) 2. are available to insureds under the defined network plan from at least 2 different providers in this state of orthotic devices and at least 2 different providers in this state of prosthetic devices that are located within a reasonable travel distance or time and whose services are covered under the plan.

2. If the provider network of the defined network plan does not include at least 2 different providers of orthotic devices and at least 2 different providers of prosthetic devices that are located within a reasonable travel distance or time for any insured, the defined network plan shall cover the services of providers of orthotic or prosthetic devices that are not in the plan's network to ensure that insureds under the plan have a choice of at least 2 different providers of orthotic devices and at least 2 different providers of prosthetic devices that are located within a reasonable travel distance or time, and may not require an insured to pay more than what the insured would have paid had the provider been in the plan's network.

3. For purposes of subds. 1. and 2., a reasonable travel distance for any insured shall be 60 miles or less and a reasonable travel time for any insured shall be 60 minutes or less.

4. A defined network plan under subd. 2. must include information in policies or certificates provided to insureds explaining the circumstances under which, and how, an insured may obtain a referral to a provider of orthotic or prosthetic devices that is not in the plan's network and must provide such information to an insured upon request.

(d) The coverage required under this subsection may not be subject to limitations, exclusions, or cost–sharing provisions that are greater than those that apply generally to services or items under the disability insurance policy or self–insured health plan.

SECTION 12. 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 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.

SECTION 13. Effective date.

(1) This act takes effect on the first day of the 7th month beginning after publication.

(END)