WISCONSIN LEGISLATIVE COUNCIL
REPORT TO THE LEGISLATURE

SPECIAL COMMITTEE ON MENTAL HEALTH PARITY

March 24, 2003

RL 2003-06

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SPECIAL COMMITTEE ON MENTAL HEALTH PARITY
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Prepared by:
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March 24, 2003

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PART I

KEY PROVISIONS OF COMMITTEE RECOMMENDATIONS

The Joint Legislative Council recommends the following proposals of the Special Committee on Mental Health Parity for introduction in the 2003-04 Session of the Legislature:

SENATE BILL 71, RELATING TO TREATMENT OF PRESCRIPTION DRUG COSTS, DIAGNOSTIC TESTING, AND PAYMENTS UNDER MANDATED INSURANCE COVERAGE OF TREATMENT FOR NERVOUS AND MENTAL DISORDERS AND ALCOHOLISM AND OTHER DRUG ABUSE PROBLEMS, AND GRANTING RULE-MAKING AUTHORITY

- Specifies that the statutory minimum coverage limits required for the treatment of nervous or mental disorders and alcoholism and other drug abuse problems do not include costs incurred for related prescription drugs or diagnostic testing.

- Provides that the statutory minimum coverage limits apply to the actual payments or reimbursement made by an insurer if the payment or reimbursement amounts are less than the amounts charged by a provider.

SENATE BILL 72, RELATING TO INCREASING THE LIMITS FOR INSURANCE COVERAGE OF NERVOUS OR MENTAL HEALTH DISORDERS OR ALCOHOLISM OR OTHER DRUG ABUSE PROBLEMS

- Increases the statutory minimum coverage limits under group health insurance policies for the treatment of nervous or mental disorders and alcoholism and other drug abuse problems by the amount of change in the federal Department of Labor's indexed cost-of-living for medical services since the inception of the required coverage limits.

- Requires the Department of Health and Family Services (DHFS) to annually report to the Governor and the Legislature on revising the coverage limits based on the change in the federal Consumer Price Index for medical costs.

PART II

COMMITTEE ACTIVITY

ASSIGNMENT

The Joint Legislative Council established the Special Committee on Mental Health Parity and appointed the co-chairs by a May 22, 2002 mail ballot. The Special Committee was directed to examine: (1) the costs and benefits of providing parity in the insurance coverage of mental illnesses in Wisconsin; (2) the experience following the enactment of the federal mental health parity law; and (3) the experiences of other states which have enacted mental health parity laws, with a view toward developing legislation in this area.

Membership of the Special Committee, appointed by a July 15, 2002 mail ballot, consisted of one Senator, two Representatives, and 11 public members. A list of committee members is included as ***Appendix 3*** to this report.

SUMMARY OF MEETINGS

The Special Committee held five meetings at the State Capitol in Madison on the following dates:

September 17, 2002
October 24, 2002
November 21, 2002
December 17, 2002
January 27, 2003

September 17, 2002. The Special Committee reviewed a staff memorandum on the federal Mental Health Parity Act and current state law on required coverage for nervous and mental disorders, alcoholism, and other drug abuse problems. The committee heard presentations from Dr. Michael Miller, F.A.S.A.M., on alcohol and drug addiction as a health problem in the context of health insurance parity; Eileen Crean, Mental Health Policy Specialist, National Conference of State Legislatures, on the federal Mental Health Parity Law, the proposed federal Mental Health Treatment Act, and states that provide benefits for mental illness, substance abuse, or both; and Pat Dunks, Milliman USA, on the issues that influence the cost of mental health benefits and the impact of mandated benefits on employers and the insurance market.

October 24, 2002. The Special Committee heard testimony from several speakers on issues related to mental health parity. Bill Stone from the Wisconsin Association for Alcohol and Other Drug Abuse presented testimony on the need for alcohol and other drug abuse services. James Guidry and Susan Ezalarab from the Office of the Commissioner of Insurance (OCI) presented information on insurance costs and described coverage of mandated benefits in insurance policies. Bill Smith of the National Federation of Independent Businesses discussed the rising costs of health insurance for small businesses and provided testimony on the characteristics of small business in Wisconsin. JP Wieske from American Medical Security, and also a member of the committee, presented information on the establishment of premiums by insurance companies. Finally, Keith Lang and Dan

Zimmerman, DHFS, provided extensive documentation on the types of services available in the state for mental health treatment and alcohol and drug abuse programs.

November 21, 2002. The Special Committee heard a presentation from Dr. Richard Davidson, University of Wisconsin-Madison, about new brain-imaging research which reveals the relationship between brain structure, brain function, and mental illness, and new technology that provides diagnostic information about mental disorders. Also, Mr. Guidry and Ms. Ezalarab, from OCI, presented information on the cost of five insurance mandates, including the mental health and substance abuse mandate, and the number of people covered by private insurance plans in Wisconsin. The committee discussed a staff memorandum regarding the statutory history of insurance mandates in Wisconsin relating to alcoholism, drug abuse, and nervous and mental disorders, and also discussed various insurance options with regard to mandated services.

December 17, 2002. The Special Committee heard testimony from individuals who have experienced financial hardship in obtaining adequate mental health services for themselves or their family members. The committee also began deliberations on possible recommendations relating to mental health parity. In this regard, the committee reviewed staff documents relating to the origins of the mental health parity financial limits, experience in other states with mental health parity legislation, and data relating to the increased health care costs since enactment of the mental health parity limits. The committee agreed to review bill drafts at their next scheduled meeting relating to the treatment of drug and diagnostic services under the financial caps and to continue discussion on the possible adjustment of the financial limits currently in place.

January 27, 2003. The Special Committee reviewed two bill drafts and voted to approve both drafts, with modifications made to one of the drafts. The committee directed staff to forward each bill draft to the Joint Legislative Council for consideration.

PART III

RECOMMENDATIONS INTRODUCED BY THE JOINT LEGISLATIVE COUNCIL

SENATE BILL 71, RELATING TO TREATMENT OF PRESCRIPTION DRUG COSTS, DIAGNOSTIC TESTING, AND PAYMENTS UNDER MANDATED INSURANCE COVERAGE OF TREATMENT FOR NERVOUS AND MENTAL DISORDERS AND ALCOHOLISM AND OTHER DRUG ABUSE PROBLEMS, AND GRANTING RULE-MAKING AUTHORITY

Background

Under s. 632.89, Stats., a group or blanket disability (health) insurance policy is required to provide coverage of nervous and mental disorders, alcoholism and other drug abuse problems. The provisions are as follows:

- If the policy provides coverage of inpatient hospital treatment or outpatient treatment or both, the policy must provide coverage of inpatient hospital services, outpatient services and transitional hospital services for the treatment of nervous and mental disorders, alcoholism, or other drug abuse (AODA) problems. Total coverage for inpatient, outpatient, and transitional services for treatment of these conditions need not exceed $7,000 or equivalent benefits measured in services rendered in any policy year. [s. 632.89 (2) (b), Stats.]

- If the policy provides coverage of any inpatient hospital treatment, it must provide coverage in every policy year for inpatient hospital services for treatment of nervous and mental disorders or AODA problems, for not less than the lesser of the expenses of 30 days as an inpatient in the hospital or $7,000, minus a co-payment of up to 10%, or $6,300. [s. 632.89 (2) (c), Stats.]

- If the policy provides coverage for outpatient services, it must provide coverage in every policy year for outpatient services for the treatment of nervous and mental disorders or AODA problems in a minimum of not less than $2,000, minus a co-payment of up to 10%, or $1,800. [s. 632.89 (2) (d), Stats.]

- If the policy provides coverage of any inpatient hospital treatment or outpatient hospital treatment, it must also provide coverage in every policy year for transitional treatment arrangements for the treatment of nervous and mental disorders and AODA problems in a minimum amount of not less than $3,000, minus a co-payment of up to 10%, or $2,700. [s. 632.89 (2) (dm), Stats.]

Inpatient hospital services are services for the treatment of nervous and mental disorders and AODA problems provided in a DHFS-approved private or public treatment facility. [s. 632.89 (1) (d), Stats.] Outpatient services include nonresidential services for these conditions provided through a program in an outpatient treatment facility if DHFS approves both the program and the facility. [s. 632.89 (1) (e), Stats.] Transitional services are

services for the treatment of nervous and mental disorders and AODA problems that are provided in a less restrictive manner than are inpatient hospital services, but in a more intensive manner than outpatient services. [s. 632.89 (1) (f), Stats.] The following types of transitional treatment services are provided:

- Mental health services for adults in a day treatment program offered by a DHFS-certified provider.

- Mental health services for children and adolescents in a day treatment program offered by a DHFS-certified provider.

- Services for persons with chronic mental illness provided through a community support program certified by DHFS.

- Residential treatment programs certified by DHFS for alcohol or drug dependent persons.

- Services for alcoholism and other drug problems provided in a day treatment program certified by DHFS.

- Intensive outpatient programs for the treatment of psychoactive substance abuse disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine.

[s. Ins 3.37, Wis. Adm. Code.]

Health care plans offered by limited services health organizations are exempt from these requirements.

Federal Mental Health Parity Act

The "Federal Mental Health Parity Act" was enacted in 1996 as part of H.R. 3666 [P.L. 104-204] relating to the Departments of Veterans Affairs and Housing and Urban Development and independent agencies' appropriations.

The Act contains two provisions relating to parity in the application of certain limits to mental health benefits. The first provision, Sec. 702, makes changes in required coverage under the federal Employee Retirement Income Security Act (ERISA) of 1974 for self-insured health plans of employers.

The second provision, Sec. 2705, contains a requirement applicable to all group health plans. It provides, in pertinent part, that in the case of a group health plan (or health insurance offered in connection with such a plan), that provides both medical and surgical benefits and mental health benefits, if the plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits. Also, if the plan does include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage must either: (a) apply the applicable lifetime limit to both the medical and surgical benefits to which it otherwise would

apply and to the mental health benefits and not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or (b) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

With respect to annual limits, if a plan provides both medical and surgical benefits and mental health benefits and if the plan does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits. Also, if it does include an annual limit on substantially all medical and surgical benefits, the plan or coverage must either: (a) apply the annual applicable limit to both the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or (b) not include any annual limit on mental health benefits that is less than the applicable annual limit.

The Act further provides that nothing in the law shall be construed: (a) to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or (b) in the case of a group plan (or health insurance coverage offered in connection with the plan) that does provide mental health benefits, as affecting the terms and conditions (including cost-sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity), relating to the amount, duration or scope of mental health benefits under the plan or coverage, except as specifically provided above.

The law also contains two exemptions: (a) it does not apply to any group health plan and any group health insurance coverage offered in connection with the group health plan for a small employer (employers with 50 or fewer employees); and (b) it does not apply with respect to a group health plan or health insurance coverage offered in connection with a plan if the application of the new law to the plan or to the coverage results in an increase in the cost of at least one percent.

The federal Act defines mental health benefits as benefits with respect to mental health services but not including benefits with respect to treatment of substance abuse or chemical dependency.

The amendments apply with respect to group health plans for plan years beginning on or after January 1, 1998.

The federal law was initially scheduled to "sunset" effective with services furnished on or after September 30, 2001. However, legislation was passed in January 2002 to extend the sunset date to December 31, 2003. Thus, the federal Act will not apply to benefits for services furnished on or after December 31, 2003.

Applicability of Federal Law and Current State Mandated Coverage Law

While the federal Mental Health Parity Law does not require group health plans to provide coverage for mental health benefits, state law contains such a requirement for insured plans. The current law on mandatory coverage of mental health and AODA benefits does not apply to self-insured plans. ERISA preempts the application of state insurance laws to private

self-insured health care plans, but not to governmental self-insured health care plans. However, the current state law on mandatory coverage of mental health and AODA benefits does not apply to governmental self-insured plans, which are state, county, city, village, town, or school district health plans. [s. 632.745 (24), Stats.]

The federal Mental Health Parity Law and the current state law on mandatory coverage apply as follows:

- Group health insurance plans for groups of two to 50 employees are subject to the current state mandated coverage law, but not the federal Mental Health Parity Law. Therefore, those insurance plans are required to provide the coverage for mental health services required under state law and are not subject to the provisions of the federal law that restrict the use of annual and lifetime limits on mental health benefits.

- Group health insurance plans for groups of more than 50 employees are subject to both the state mandated insurance coverage law and the federal Mental Health Parity Law. Therefore, they are required to offer coverage of mental health benefits under the state law and are restricted in the ability to impose annual or lifetime limits on mental health benefits as provided in the federal law.

- Self-insured plans for two to 50 employees are subject to neither the state law nor the federal mental health parity law.

- Self-insured plans for more than 50 employees are not subject to the state mandated coverage law, but are subject to the federal Mental Health Parity Law. Therefore, they are not required to offer coverage of mental health benefits, but if they do so, they will be subject to the restrictions in the federal law on annual and lifetime limits on mental health benefits.

These situations only discuss coverage of mental health benefits. As mentioned earlier, the state mandated coverage law also includes AODA benefits, while the federal Mental Health Parity Law does not.

SENATE BILL 72, RELATING TO INCREASING THE LIMITS FOR INSURANCE COVERAGE OF NERVOUS OR MENTAL HEALTH DISORDERS OR ALCOHOLISM OR OTHER DRUG ABUSE PROBLEMS

Background

Under current law, a group health insurance policy that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and AODA problems in the minimum amount of the lesser of: (a) the expenses of 30 days of inpatient services; or (b) $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered.

If a group health insurance policy provides coverage of any outpatient hospital services, it must cover those services for the treatment of nervous and mental disorders and

AODA problems in the minimum amount of $2,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered.

If a group health insurance policy provides coverage of any inpatient or outpatient hospital services, it must cover the cost of transitional treatment arrangements for the treatment of nervous and mental disorders and AODA problems in the minimum amount of $3,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered.

If a group health insurance policy provides coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for nervous and mental disorders and AODA problems is not required to exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year.

The committee heard testimony from OCI, regarding OCI's 2001 Study of Costs of Mandated Benefits in Insurance Policies. According to the OCI study, prescription drug costs associated with the treatment of mental health and AODA problems are generally not counted against the mandated coverage limits. Public Member Wieske also noted that this is the current general practice in the insurance industry.

The committee also heard testimony from OCI and committee members that diagnostic services associated with the identification of mental health illnesses are generally not charged against the mental health and AODA coverage limits.

Public Member Wieske stated that the current general practice in the insurance industry is that if an insurer pays less than the amount that a health care provider charges, the minimum coverage limits apply to the actual amount paid by the insurer not to the amount charged by the provider.

Description of Bill

The bill specifies that the minimum coverage limits required for the treatment of nervous and mental disorders and AODA problems do not include costs incurred for prescription drugs or diagnostic testing. Thus, charges for prescription drugs or diagnostic testing would not be counted against the statutory coverage limits. Diagnostic testing is defined in the bill as procedures used to exclude the existence of conditions other than nervous or mental disorders or alcoholism or other drug abuse problems. The DHFS is authorized to specify, by rule, the diagnostic testing procedures that are not included under the coverage limits.

The bill also provides that, if an insurer pays less than the amount that a provider charges, the required minimum coverage limits apply to the amount actually paid by the insurer rather than to the amount charged by the provider.

Finally, the bill provides that if an insurance policy contains a provision that is inconsistent with the new provisions, the new requirements will first apply on the date the policy is renewed.

SENATE BILL 72

Background

Under current law, if a group health insurance policy provides coverage of any inpatient hospital treatment, it must provide coverage for the treatment of nervous and mental disorders or AODA problems for not less than the lesser of the expenses of 30 days as an inpatient in the hospital or $7,000, or $6,300 if the plan contains no cost-sharing provisions. If the policy provides coverage for outpatient services, it must provide coverage for outpatient services for the treatment of nervous and mental disorders or AODA problems of not less than $2,000, or $1,800 if the plan contains no cost sharing provisions. If the policy provides coverage for inpatient or outpatient hospital treatment, it must provide coverage for transitional treatment arrangements for the treatment of nervous and mental disorders or AODA problems of not less than $3,000, or $2,700 if the plan contains no cost sharing provisions.

The minimum coverage amount for inpatient hospital treatment was enacted in 1985. The minimum coverage amounts for outpatient services and for transitional treatment services were each enacted in 1992.

Description of Bill

This bill increases the coverage limits under group health insurance policies for treatment for nervous and mental disorders and for AODA problems. Specifically, the various coverage amounts would be increased by the amount of change in the federal Department of Labor, Bureau of Labor Statistics indexed cost-of-living for medical services since the inception of the required coverage amounts. The table below provides information on treatment category, current minimum coverage amount, year of enactment, and the proposed coverage amounts based on the increase in the federal cost-of-living for medical coverage "indexed" since the enactment of the coverage amounts.

Treatment	*Current Minimum Coverage Amount*	*Year Enacted*	*Proposed Coverage Amounts*
Inpatient			
Cost-sharing	$7,000 minus cost-sharing	1985	$16,800
No cost-sharing	$6,300	1985	$15,100
Outpatient			
Cost-sharing	$2,000 minus cost-sharing	1992	$3,100
No cost-sharing	$1,800	1992	$2,800
Transitional			
Cost-sharing	$3,000 minus cost-sharing	1992	$4,600
No cost-sharing	$2,700	1992	$4,100

Treatment	*Current Minimum Coverage Amount*	*Year Enacted*	*Proposed Coverage Amounts*
All services	$7,000	1985	$16,800

The bill requires DHFS to annually report to the Governor and Legislature on the change in coverage limits necessary to conform with the change in the federal Consumer Price Index for medical costs.

The bill also contains a delayed initial applicability provision which states the new coverage amounts will first apply to policies issued, renewed, or modified on the first day of the 13th month beginning after the bill becomes law.

APPENDIX 1

Committee and Joint Legislative Council Votes

The Special Committee voted to recommend WLC: 0119/1 and WLC: 0120/1, as amended, to the Joint Legislative Council for introduction in the 2003-04 Session of the Legislature.

SPECIAL COMMITTEE VOTES

- WLC: 0119/1, relating to treatment of prescription drug costs, diagnostic testing, and payments under mandated coverage of mental health and alcoholism and other drug abuse problems: Ayes, 14 (Sen. Hansen; Reps. Vrakas and Lehman; and Public Members Beilman, Frett, Gross, Krumholz, Moulthrop, Reider, Rosenzweig, Schick, Slota-Varma, Wieske, and Yunk); Noes, 0; and Absent, 0. [The recommended proposal was subsequently drafted as LRB-1978/2.]

- WLC: 0120/1, relating to increasing coverage limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems: Ayes, 8 (Sen. Hansen; Rep. Lehman; and Public Members Beilman, Gross, Moulthrop, Rosenzweig, Slota-Varma, and Yunk); Noes, 6 (Rep. Vrakas; and Public Members, Frett, Krumholz, Reider, Schick, and Wieske); Absent, 0. [The recommended proposal was subsequently drafted as LRB-1979/1.]

JOINT LEGISLATIVE COUNCIL VOTES

The Joint Legislative Council voted to recommend the proposed bill drafts on March 12, 2003. The votes on the drafts were as follows:

> *Rep. Freese moved, seconded by Sen. Panzer, that LRB-1978/2, relating to treatment of prescription drug costs, diagnostic testing, and payments under mandated insurance coverage of treatment for nervous and mental disorders and alcoholism and other drug abuse problems and granting rule-making authority, be introduced by the Joint Legislative Council. The motion passed by a voice vote.*
>
> > *[Sen. Welch asked that the record reflect that he voted "no" on LRB-1978/2.]*
>
> *Sen. Erpenbach moved, seconded by Rep. Coggs, that LRB-1979/1, relating to increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems, be introduced by the Joint Legislative Council. The motion passed on a roll call vote as follows:*

Ayes, 13 (Sens. Erpenbach, Harsdorf, Panzer, and Risser; and Reps. Coggs, Foti, Freese, Kaufert, Kreuser, Lehman, Schneider, Townsend, and Travis); Noes, 4 (Sens. Lasee, Darling, and Welch; and Rep. Wieckert); Absent, 4 (Sens. Decker, Ellis, and George; and Rep. Gard); and Vacancy, 1.

[Rep. Gard noted that had he been present, he would have voted "Aye" on LRB-1979/1.]

APPENDIX 2

JOINT LEGISLATIVE COUNCIL
s. 13.81, Stats.

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This 22-member committee consists of the majority and minority party leadership of both houses of the Legislature, the cochairs and ranking minority members of the Joint Committee on Finance, and 5 Senators and 5 Representatives appointed as are members of standing committees.

APPENDIX 3

MENTAL HEALTH PARITY

Senator David Hansen, **Co-Chair**
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JP Wieske
American Medical Security
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Representative John W. Lehman
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Representative Daniel P. Vrakas, **Co-Chair**
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Patty Yunk
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Milwaukee, WI 53208

STUDY ASSIGNMENT: The Committee is directed to study the costs and benefits of providing parity in the insurance coverage of mental illnesses in Wisconsin. The Special Committee shall study the experience following the enactment of the federal mental health parity law and shall examine the experiences of other states which have enacted mental health parity laws, with a view toward developing legislation in this area.

Established and Co-Chairs appointed by a May 22, 2002 mail ballot; members appointed by a July 15, 2002 mail ballot.

14 MEMBERS: 1 Senator; 2 Representatives; and 11 Public Members.

LEGISLATIVE COUNCIL STAFF: Russ Whitesel, Senior Staff Attorney; Rachel Letzing, Staff Attorney; and Tracey Uselman, Support Staff.

APPENDIX 4

Committee Materials List

January 27, 2003 Meeting

Memorandum, **Proposals to the Special Committee on Mental Health Parity** (1-21-03)

WLC: 0119/1, relating to treatment of prescription drug costs, diagnostic testing, and payments under mandated coverage of mental health and alcoholism and other drug abuse problems

WLC: 0120/1, relating to increasing the coverage limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems

Section 632.89, Stats.

December 17, 2002 Meeting

Memo No. 3, **State Insurance Laws With Cost Exemptions** (12-6-02)

Memo No. 4, **Issues Related to Mental Health Parity** (12-9-02)

Article, **Laws in the Making**, distributed by Public Member Robert Reider (11/12-02)

Article, **Doctors Consider Diagnosis for "Ill" Relationships**, distributed by Public Member Alan Krumholz (9-1-02)

Article, **An Early Case Study of the Effects of California's Mental Health Parity Legislation**, distributed by Public Member Kitty Slota-Varma (10-22-02)

Handout, Wisconsin - All industries, U.S. Census Bureau

Memorandum from **Bob Lang**, Legislative Fiscal Bureau (05-07-85)

Excerpt, **Summary of Budget Modifications Volume II** (1985 Wisconsin Act 29)

Testimony, **Mary Conroy**

November 21, 2002 Meeting

Memo No. 2, **Statutory History of Insurance Mandates in Wisconsin Relating to Alcoholism, Drug Abuse, and Nervous and Mental Disorders** (11-11-02)

Report, **Study of Costs of Certain Mandated Benefits in Insurance Policies 2001**, submitted by the Office of the Commissioner of Insurance (10-02)

Report, **Interim Report to the President**, prepared by the President's New Freedom Commission on Mental Health (10-29-02)

Summary, **President's New Freedom Commission on Mental Health**, prepared by the President's New Freedom Commission on Mental Health (11-1-02)

Report, **Health Insurance Coverage in Wisconsin,** submitted by the Office of the Commissioner of Insurance (7-02)

Memorandum from **Joyce Allen** and **Keith Lang,** Department of Health and Family Services, relating to response to study committees' questions of October 24 (11-21-02)

October 24, 2002 Meeting

Testimony, **Bill Stone,** Wisconsin Association for Alcohol and Other Drug Abuse

Handouts from **Jim Guidry,** Legislative Liaison, Office of the Commissioner of Insurance:

Fact Sheet on **Mandated Benefits in Health Insurance Policies** (7-2002)

Consumer's Guide to **Managed Care Health Plans in Wisconsin** (6-2002)

Letter, **Social and financial impact report--Senate Bill 157** (10-16-02)

Fact Sheet on **Mandated Benefits for the Treatment of Nervous and Mental Disorders, Alcoholism, and Other Drug Abuse** (11-2000)

Bulletins to Insurers, **Newly Enacted Legislation, 1999 Wisconsin Act 9 and 1997 Wisconsin Act 231** (1-10-00)

Bulletins to Insurers, **Mental Health Parity** (4-28-98)

Insurance Issues Paper, **Study of Costs of Mandated Benefits Report on Phase II**

Report, **Costs of Mandated Benefits, 1990**

Draft Report, **Study of Costs of Mandated Benefits in Insurance Policies, 2001** (10-2002)

Chart, **Summary of Survey Results, Survey of 2001 Insurance Benefit Mandates** (10-23-02

Testimony, **Bill Smith,** National Federation of Independent Businesses

Presentation, **JP Wieske,** Government Affairs, American Medical Security

Testimony, **Keith Lang** and **Dan Zimmerman,** Department of Health and Family Service

September 17, 2002 Meeting

Memo No. 1, **Mental Health Parity** (8-29-02)

Testimony, **Dr. Michael Miller,** Middleton, Wisconsin

Testimony, **Eileen Crean,** Mental Health Policy Specialist, National Conference of State Legislatures, Washington, D.C.

Testimony, **Pat Dunks,** Milliman, USA, Brookfield, Wisconsin

Senate Committee on Health, Children, Families, Aging and Long Term Care

Attendance of Members

The following members will be at the hearing: Senators Brown, Carpenter, Chvala (?) Jauch, Welch (may be late), Schultz and Robson.

EXCUSED

Kanavas will not be attending. Chvala - not attending

Roll Call at end of Day

Voting

Executive Session

The hearing notice states," An Executive Session will be held on SB 71, SB 72, and SB 192. An Executive Session may be held on any of the other items before the Committee."

Public Hearing was held on 1-22-03

Senate Bill 71:

- Treatment of prescription drug costs, diagnostic testing, and payments under mandated insurance coverage of treatment for nervous and mental disorders and alcoholism and other drug abuse problems.
- Mental Health Parity Legislative Council Study Committee: 14ayes, 0 noes; Joint Legislative Council: voice vote with Welch recorded as no.
- Welch will be voting against on Sept. 4th. Kanavas will likely vote yes.

Senate Bill 72:

- Increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems.
- Mental Health Parity Legislative Council Study Committee-8 ayes, 6noes; Joint Legislative Council-13ayes, 4 noes, 1 absent-Gard would have voted aye.
- Welch, Kanavas and Brown will be voting against on Sept. 4th. Care given Back ground check

Senate Bill 192

{Conducted on a person convicted of a serious crime, has abused or neglected a client or child etc...

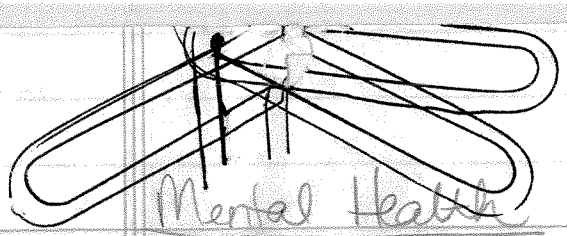
- Tribal administration of rehabilitation reviews for persons who otherwise may not operate, be employed at, contract with, or reside at an entity that provides care for children or adults.
- State Tribal Relations Legislative Council Study Committee-12 ayes, 1 no, 4 not voting; Joint Legislative Council-15 ayes, 2 noes, 4 not voting-Foti would have voted no.

Rehab, tribal

Agenda

Senate Bill 230- You are the main author

- HIV testing bill.
- Authorizes an employee of a school district, cooperative educational service agency, charter school, private school, the WI Educational Services Program for the Deaf and Heard of Hearing, the WI Center for the Blind and Visually Impaired, or a social



Mental Health

JFC - JFC exempted drugs to treat mental illness, including depression, psychoses and bipolar disorders from the prior authorization requirement

JFC - prior authorization could be required for new prescriptions for SSRI's - prescriptions for patients already stabilized on an SSRI would not require prior authorization

Senate - Direct creation of a Mental Health Medication Review Committee to advise DHFS on implementation of prior authorization requirements for SSRIs

SSRI = Selective serotonin reuptake inhibitors

LRB–1979/1
PJK:kmg:jf

2003 SENATE BILL 72

March 13, 2003 – Introduced by JOINT LEGISLATIVE COUNCIL. Referred to Committee on Health, Children, Families, Aging and Long Term Care.

AN ACT ***to amend*** 632.89 (2) (b) 1., 632.89 (2) (c) 2. b., 632.89 (2) (d) 2. and 632.89 (2) (dm) 2.; and ***to create*** 632.89 (1) (am) and 632.89 (2) (f) of the statutes; **relating to:** increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems.

Analysis by the Legislative Reference Bureau

This bill is explained in the NOTE provided by the Joint Legislative Council in the bill.

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:

JOINT LEGISLATIVE COUNCIL PREFATORY NOTE: This bill was prepared for the joint legislative council's special committee on mental health parity.

Under current law, a group health insurance policy (called a "disability insurance policy" in the statutes) that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of

any outpatient hospital services, it must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $2,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any inpatient or outpatient hospital services, it must cover the cost of transitional treatment arrangements (services, specified by rule by the commissioner of insurance, that are provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services) for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $3,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems is not required to exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year.

This bill changes the minimum amount of coverage that must be provided for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems on the basis of the change in the consumer price index for medical services since the coverage amounts in current law were enacted. Inpatient services must be covered in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $16,800 minus the applicable cost sharing or, if there is no cost sharing under the policy, $15,100 in equivalent benefits measured in services rendered. Outpatient services must be covered in the minimum amount of $3,100 minus the applicable cost sharing or, if there is no cost sharing under the policy, $2,800 in equivalent benefits measured in services rendered. Transitional treatment arrangements must be covered in the minimum amount of $4,600 minus the applicable cost sharing or, if there is no cost sharing under the policy, $4,100 in equivalent benefits measured in services rendered. The total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems is not required to exceed $16,800, or the equivalent benefits measured in services rendered, in a policy year.

The table below provides information on treatment category, current minimum coverage amount, year of enactment and the proposed coverage amounts based on the increase in the federal cost–of–living for medical coverage "indexed" since the enactment of the coverage amounts.

Treatment	*Current Minimum Coverage Amount*	*Year Enacted*	*Proposed Coverage Amounts*
Inpatient			
Cost sharing	$7,000 minus cost sharing	1985	$16,800
No cost sharing	$6,300	1985	$15,100
Outpatient			
Cost sharing	$2,000 minus cost sharing	1992	$3,100
No cost sharing	$1,800	1992	$2,800
Transitional			
Cost sharing	$3,000 minus cost sharing	1992	$4,600
No cost sharing	$2,700	1992	$4,100
All services	$7,000	1985	$16,800

The bill also requires the department of health and family services to annually report to the governor and legislature on the change in coverage limits necessary to conform with the change in the federal consumer price index for medical costs.

The bill also contains a delayed initial applicability provision which states the new coverage amounts will first apply to policies issued, renewed, or modified on the first day of the 13th month beginning after the bill becomes law.

SECTION 1. 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 2. 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~~ $16,800 or the equivalent benefits measured in services rendered.

SECTION 3. 632.89 (2) (c) 2. b. of the statutes is amended to read:

632.89 **(2)** (c) 2. b. ~~Seven thousand~~ Sixteen thousand eight hundred 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~~ $15,100 in equivalent benefits measured in services rendered.

SECTION 4. 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~~ $3,100 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~~ $2,800 in equivalent benefits measured in services rendered.

SECTION 5. 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~~ $4,600 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~~ $4,100 in equivalent benefits measured in services rendered.

SECTION 6. 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 7. Initial applicability.

(1) This act first applies to a policy issued, renewed, or modified on the first day of the 13th month beginning after publication.

(END)