2003 SENATE BILL 72

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

1 AN ACT ***to amend*** 632.89 (2) (b) 1., 632.89 (2) (c) 2. b., 632.89 (2) (d) 2. and 632.89
2 (2) (dm) 2.; and ***to create*** 632.89 (1) (am) and 632.89 (2) (f) of the statutes;
3 **relating to:** increasing the limits for insurance coverage of nervous or mental
4 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)