LRB–1978/en
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# 2003 SENATE BILL 71

AN ACT ***to create*** 632.89 (1) (b) and 632.89 (6) and (7) of the statutes; **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.

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

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***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 specifies that the minimum coverage limits required for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems do not include costs incurred for prescription drugs and diagnostic testing. 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 Department of Health and Family Services 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.

**SECTION 1.** 632.89 (1) (b) of the statutes is created to read:

632.89 **(1)** (b) "Diagnostic testing" means procedures used to exclude the existence of conditions other than nervous or mental disorders or alcoholism or other drug abuse problems.

**SECTION 2.** 632.89 (6) and (7) of the statutes are created to read:

632.89 **(6)** PRESCRIPTION DRUGS AND DIAGNOSTIC TESTING. (a) The coverage amounts specified in sub. (2) shall not include costs incurred for prescription drugs or diagnostic testing.

(b) The department of health and family services may specify, by rule, the diagnostic testing procedures to which par. (a) applies.

**(7)** TREATMENT OF COSTS. The coverage amounts specified in sub. (2) apply to actual payments or reimbursements made by an insurer if the payment or reimbursement amounts are less than the amounts charged by a provider.

**SECTION 3. Initial applicability.**

(1) If an insurance policy that is in effect on the effective date of this subsection contains a provision that is inconsistent with the treatment of section 632.89 (6) or (7) of the statutes, the treatment of section 632.89 (6) or (7) of the statutes, whichever is inconsistent, first applies to that insurance policy on the date on which it is renewed.

**(END)**