

## 2009 DRAFTING REQUEST

### Bill

Received: **09/09/2009**

Received By: **pkahler**

Wanted: **As time permits**

Identical to LRB:

For: **Sandy Pasch (608) 266-7671**

By/Representing: **Fred Ludwig**

This file may be shown to any legislator: **NO**

Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Insurance - health**

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Pasch@legis.wisconsin.gov**

Carbon copy (CC:) to:

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### Pre Topic:

No specific pre topic given

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### Topic:

Mental health parity (under health insurance policies)

---

### Instructions:

See attached

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### Drafting History:

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Typed</u>	<u>Proofed</u>	<u>Submitted</u>	<u>Jacketed</u>	<u>Required</u>
/?	pkahler 09/10/2009	jdyer 09/15/2009		_____			S&L
/P1			phenry 09/15/2009	_____	mbarman 09/15/2009		S&L
/P2	pkahler 09/21/2009	jdyer 09/22/2009	phenry 09/22/2009	_____	sbasford 09/22/2009		S&L
/1	pkahler	jdyer	phenry	_____	lparisi		S&L

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	09/24/2009 pkahler 09/30/2009	09/29/2009 jdye 09/30/2009	09/30/2009 _____ rschluet _____ 09/30/2009 _____		09/30/2009		
/2	pkahler 10/01/2009	jdye 10/01/2009	jfrantze 10/01/2009 _____		sbasford 10/01/2009	mbarman 10/21/2009	

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↳ At Intro.

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			<i>10/1 vkgf</i>				

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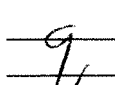
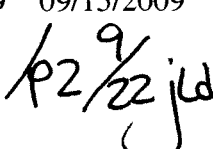
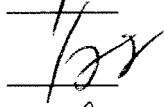

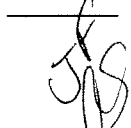
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/?	pkahler	PI 9/15 JLD	9/15 pkh	9/15 JK AS			

FE Sent For:

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John to consult w/OCI  
re. fed resp status

**Kahler, Pam**

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**From:** Ludwig, Frederic  
**Sent:** Tuesday, September 08, 2009 2:46 PM  
**To:** Kahler, Pam  
**Cc:** Sweet, Richard; Wagnitz, John  
**Subject:** RE: Parity options

Pam,

Rep. Pasch would like to request a bill draft relating to mental health parity. She would like to use 2007 Senate Bill 375 as the foundation with the following changes:

1. Substitute s. 632.89(3), Stats., (page 9, lines 21 to 25) with the following language:  
(c) *Limitations.* The exclusions and limitations; deductibles; copayments; coinsurance; annual and lifetime payment limits; out-of-pocket limits; out-of-network charges; day, visit, or appointment limits; duration or frequency of coverage limits; for plans under this subsection may be no more restrictive for coverage for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems than the predominant treatment limitations applied to substantially all physical condition coverage under the plan. The plan shall include in any overall deductible amount for the plan expenses incurred for treatment of nervous and mental disorders and alcoholism and other drug abuse problems. In this paragraph, "predominant" means the most common or frequent type of limitation.
2. Add a new paragraph (d) with the following language:  
(d) *Availability of plan information.* The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary.

Let me know if you need any further information, Pam. Per the string of emails below, you'll see that we have been working closely with Dick on language over the past couple weeks, so he said you should feel free to contact him with any questions as well.

Thanks,  
Fred

--  
Fred Ludwig  
**Office of Representative Sandy Pasch**  
608.266.7671 (Office)  
888.534.0022 (Toll-free)  
608.282.3622 (Fax)

---

**From:** Sweet, Richard  
**Sent:** Tuesday, September 08, 2009 9:27 AM  
**To:** Ludwig, Frederic; Wagnitz, John  
**Subject:** RE: Parity options

Fred/John,

Sounds like what you want to do is ask the drafter (Pam Kahler from LRB) to: **(1)** start with

Fred Ludwig  
Office of Representative Sandy Pasch  
608.266.7671 (Office)  
888.534.0022 (Toll-free)  
608.282.3622 (Fax)

---

**From:** Sweet, Richard  
**Sent:** Friday, August 28, 2009 11:33 AM  
**To:** Ludwig, Frederic  
**Cc:** Wagnitz, John  
**Subject:** Parity options

Fred,

Shown below are a couple of alternatives to replace the language in proposed s. 632.89(3), Stats., as shown on page 9, lines 21 to 25 of 2007 Senate Bill 375:

### **Option 1**

This option would use language similar to what was used in the recent Budget Act on the contraceptives mandate, which stated:

632.895(17)(c) Coverage under par. (b) may be subject only to the exclusions, limitations, or cost-sharing provisions that apply generally to the coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices that is provided under the policy or self-insured health plan.

If this type of language is used for parity, it could be modified to read:

(c) *Limitations.* Coverage under this subsection may be subject only to exclusions, limitations, or cost-sharing provisions that apply generally to the coverage of physical health conditions.

### **Option 2**

This option would be based on the language from Senate Bill 375, but modified to be similar to what was used in the federal mental health parity statute. It could be drafted along the following lines:

(c) *Limitations.* The exclusions and limitations; deductibles; copayments; coinsurance; annual and lifetime payment limits; out-of-pocket limits; out-of-network charges; day, visit, or appointment limits; duration or frequency of coverage limits; and medical necessity definitions; for plans under this subsection may be no more restrictive for coverage for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems than the predominant treatment limitations applied to substantially all physical condition coverage under the plan. The plan shall include in any overall deductible amount for the plan expenses

2007 Senate Bill 375; **(2)** substitute par. (c) below from option 2 but without the language on medical necessity determinations; and **(3)** add a new par. (d) that is based on item (4) from the federal law quoted by Shel, but probably without the language "in accordance with regulations".

If you want to have Pam give me a call if she has any questions, that would be fine. You may want to forward this e-mail to her, so that she knows where you want to go.

## *Dick Sweet*

Senior Staff Attorney  
Wisconsin Legislative Council  
(608)266-2982  
richard.sweet@legis.wisconsin.gov

---

**From:** Ludwig, Frederic  
**Sent:** Friday, September 04, 2009 11:32 AM  
**To:** Sweet, Richard; Wagnitz, John  
**Subject:** RE: Parity options

It's been one hell of a week in the Pasch office, so just want to do a full circle here. Dick... would you be able to make these final changes per Shel's suggestion? I believe that is all that would need to be done in order to have something ready for drafting, but let me know what you think or if I'm missing something here.

--

Fred Ludwig  
**Office of Representative Sandy Pasch**  
608.266.7671 (Office)  
888.534.0022 (Toll-free)  
608.282.3622 (Fax)

---

**From:** Sweet, Richard  
**Sent:** Tuesday, September 01, 2009 10:20 AM  
**To:** Wagnitz, John; Ludwig, Frederic  
**Subject:** RE: Parity options

I just included it here since it was in 2007 Senate Bill 375, but the federal law seems to be clearer. Seems like a good move.

Dick

---

**From:** Wagnitz, John  
**Sent:** Tuesday, September 01, 2009 9:52 AM  
**To:** Ludwig, Frederic; Sweet, Richard  
**Subject:** RE: Parity options

Hi Fred,

I agree, option #2 works best. I also like Shel's suggestion with respect to moving the medical necessity language .

John

---

**From:** Ludwig, Frederic  
**Sent:** Tuesday, September 01, 2009 8:55 AM  
**To:** Sweet, Richard  
**Cc:** Wagnitz, John  
**Subject:** RE: Parity options

Dick,

Just heard back from Shel regarding the draft language. He thought Option 2 worked best but thought we should remove the medical necessity language and place it in a separate section on availability of plan information that mirrors federal law (below). Any thoughts (Dick or John)?

plan or coverage shall ensure that—

“(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

“(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

“(B) DEFINITIONS.—In this paragraph:

“(i) FINANCIAL REQUIREMENT.—The term ‘financial requirement’ includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2),

“(ii) PREDOMINANT.—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

“(iii) TREATMENT LIMITATION.—The term ‘treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

“(4) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available H. R. 1424—118

by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

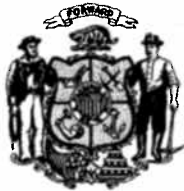
“(5) OUT-OF-NETWORK PROVIDERS.—In the case of a plan

incurred for treatment of nervous and mental disorders and alcoholism and other drug abuse problems. In this paragraph, "predominant" means the most common or frequent type of limitation.

I cc'ed John on this also. Feel free to use (or discard) either of the above, or tinker with the language. Shel and Marc may have some thoughts.

*Dick Sweet*

Senior Staff Attorney  
Wisconsin Legislative Council  
(608)266-2982  
richard.sweet@legis.wisconsin.gov



LPS-CHECK  
auto refs please

2009

2007 SENATE BILL 375

D-into

LPS-  
P.W.K.  
please

January 4, 2008 - Introduced by Senators HANSEN, LEHMAN, BRESKE, CARPENTER, KRPENBACH, HARS DORF, MILLER, RISSER, ROBSON, VINEHOUT and WIRCH, cosponsored by Representatives ALBERS, BENEDICT, BERCEAU, BLACK, BOYLE, CULLEN, FIELDS, GRIGSBY, HINTZ, KAUFERT, MASON, NELSON, A. OTT, POCAN, POPE-ROBERTS, SEIDEL, SHERIDAN, SHERMAN, SHILLING, SINICKI, SMITH, SOLETSKI, TOLES, TURNER, YOUNG and ZEPNICK. Referred to Committee on Health, Human Services, Insurance, and Job Creation.

g

regenerate ✓

4

1 AN ACT *to repeal* 632.89 (1) (em), 632.89 (2) (a) 2., 632.89 (2) (b), 632.89 (2) (c)  
2 2., 632.89 (2) (d) 2., 632.89 (2) (dm) 2., 632.89 (3m), 632.89 (6) and 632.89 (7);  
3 *to renumber* 632.89 (2m) and 632.89 (5); *to renumber and amend* 632.89 (2)  
4 (a) 1., 632.89 (2) (c) 1., 632.89 (2) (d) 1., 632.89 (2) (dm) 1. and 632.89 (2) (e); *to*  
5 *amend* 40.51 (8), 40.51 (8m), 46.10 (8) (d), 46.10 (14) (a), 66.0137 (4), 120.13 (2)  
6 (g), 185.981 (4t), 185.983 (1) (intro.), 301.12 (8) (d), 301.12 (14) (a), 632.89 (title),  
7 632.89 (2) (title) and 632.89 (5) (title); *to repeal and recreate* 632.89 (1) (b);  
8 and *to create* 111.91 (2) (qm), 609.86, 632.89 (1) (er), 632.89 (2p), 632.89 (3) and  
9 632.89 (5) (a) (title) of the statutes; **relating to:** health insurance coverage of  
10 nervous and mental disorders, alcoholism, and other drug abuse problems. ✓

**Analysis by the Legislative Reference Bureau**

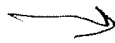
Under current law, a group health insurance policy (called a "disability insurance policy" in the statutes) that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems (mental health and substance abuse problems) in the minimum amount of the lesser of: 1) the expenses of 30 days of



SENATE BILL 375

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

\*  
\*



abuse

This bill removes the specified minimum amounts of coverage that a group health insurance policy must provide for the treatment of mental health and substance abuse problems but retains the requirements with respect to providing the coverage. Except for group plans providing limited benefits, the bill specifically applies the requirements to all types of group health benefit plans, including defined network plans, insurance plans offered by the state, and self-insured health plans of the state and municipalities.

more up to end of previous paragraph

Governmental health

In addition, the bill requires group and individual health benefit plans and governmental self-insured plans that provide coverage for the treatment of mental health and substance abuse problems and that would cover at least one annual physical examination to cover at least one annual screening for a covered individual to determine the need for treatment of mental health and substance abuse problems and for a female covered under the plan at least one screening during a pregnancy for prepartum depression and at least one screening within six months after a live birth, stillbirth, or miscarriage for postpartum depression to determine the need for treatment. The bill also imposes a new requirement that the coverage under group health benefit plans and governmental self-insured health plans for the treatment of mental health and substance abuse problems must be the same as the coverage under those plans for the treatment of physical conditions. This requirement for equal coverage applies to such coverage components as deductibles, copayments, annual and lifetime limits, and medical necessity definitions. The bill does not require individual health benefit plans to cover the treatment of mental health and substance abuse problems but, if an individual health benefit plan does cover the treatment of any of those conditions, the individual health benefit plan must provide the same coverage for that treatment as it does for the treatment of physical conditions.

The bill also imposes a new requirement that the coverage under group health benefit plans and governmental self-insured health plans for the treatment of mental health and substance abuse problems must be the same as the coverage under those plans for the treatment of physical conditions. This requirement for equal coverage applies to such coverage components as deductibles, copayments, annual and lifetime limits, and medical necessity definitions. The bill does not require individual health benefit plans to cover the treatment of mental health and substance abuse problems but, if an individual health benefit plan does cover the treatment of any of those conditions, the individual health benefit plan must provide the same coverage for that treatment as it does for the treatment of physical conditions.

Insert A

**SENATE BILL 375**

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:*

1 ✓ **SECTION 1.** 40.51 (8) of the statutes, as affected by 2007 Wisconsin Act 36, is  
2 amended to read:

3 40.51 (8) Every health care coverage plan offered by the state under sub. (6)  
4 shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8)  
5 and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to  
6 (5) ~~(6)~~, ~~632.89~~, 632.895 (5m) and (8) to (15), and 632.896.

7 ✓ **SECTION 2.** 40.51 (8m) of the statutes, as affected by 2007 Wisconsin Act 36, is  
8 amended to read:

9 40.51 (8m) Every health care coverage plan offered by the group insurance  
10 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,  
11 632.748, 632.83, 632.835, 632.85, ~~632.853~~, 632.855, ~~632.89~~, and 632.895 (11) to (15).

12 ✓ **SECTION 3.** 46.10 (8) (d) of the statutes is amended to read:

13 46.10 (8) (d) After due regard to the case and to a spouse and minor children  
14 who are lawfully dependent on the property for support, compromise or waive any  
15 portion of any claim of the state or county for which a person specified under sub. (2)  
16 is liable, but not any claim payable by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or  
17 by any other 3rd party.

18 ✱ **SECTION 4.** 46.10 (14) (a) of the statutes is amended to read:

19 46.10 (14) (a) Except as provided in pars. (b) and (c), liability of a person  
20 specified in sub. (2) or s. 46.03 (18) for inpatient care and maintenance of persons  
21 under 18 years of age at community mental health centers, a county mental health

**SENATE BILL 375****SECTION 4**

1 complex under s. 51.08, the centers for the developmentally disabled, the Mendota  
2 Mental Health Institute, and the Winnebago Mental Health Institute or care and  
3 maintenance of persons under 18 years of age in residential, nonmedical facilities  
4 such as group homes, foster homes, treatment foster homes, subsidized  
5 guardianship homes, residential care centers for children and youth, and juvenile  
6 correctional institutions is determined in accordance with the cost-based fee  
7 established under s. 46.03 (18). The department shall bill the liable person up to any  
8 amount of liability not paid by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or by other  
9 3rd-party benefits, subject to rules that include formulas governing ability to pay  
10 promulgated by the department under s. 46.03 (18). Any liability of the patient not  
11 payable by any other person terminates when the patient reaches age 18, unless the  
12 liable person has prevented payment by any act or omission.

13 ✓ **SECTION 5.** 66.0137 (4) of the statutes, as affected by 2007 Wisconsin Act 36,  
14 is amended to read:

15 66.0137 (4) **SELF-INSURED HEALTH PLANS.** If a city, including a 1st class city, or  
16 a village provides health care benefits under its home rule power, or if a town  
17 provides health care benefits, to its officers and employees on a self-insured basis,  
18 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),  
19 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4) and,  
20 (5), ~~and (6), 632.89,~~ 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

21 ✓ **SECTION 6.** 111.91 (2) (qm) of the statutes is created to read:

22 111.91 (2) (qm) The requirements under s. 632.89 relating to coverage of  
23 screening and treatment for nervous and mental disorders and alcoholism and other  
24 drug abuse problems.

**SENATE BILL 375**

1 **SECTION 7.** 120.13 (2) (g) of the statutes, as affected by 2007 Wisconsin Act 36,  
2 is amended to read:

3 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.  
4 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),  
5 632.85, 632.853, 632.855, 632.87 (4) and (5), and (6), 632.89, 632.895 (9) to (15),  
6 632.896, and ~~767.25 (4m)~~ (d) 767.513 (4).

7 **SECTION 8.** 185.981 (4t) of the statutes, as affected by 2007 Wisconsin Act 36,  
8 is amended to read:

9 185.981 (4t) A sickness care plan operated by a cooperative association is  
10 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85,  
11 632.853, 632.855, 632.87 (2m), (3), (4), and (5), and (6), 632.89, 632.895 (10) to (15),  
12 and 632.897 (10) and chs. 149 and 155.

13 **SECTION 9.** 185.983 (1) (intro.) of the statutes, as affected by 2007 Wisconsin  
14 Act 36, is amended to read:

15 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be  
16 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,  
17 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,  
18 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853,  
19 632.855, 632.87 (2m), (3), (4), and (5), and (6), 632.89, 632.895 (5) and (9) to (15),  
20 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring  
21 association shall:

22 **SECTION 10.** 301.12 (8) (d) of the statutes is amended to read:

23 301.12 (8) (d) After due regard to the case and to a spouse and minor children  
24 who are lawfully dependent on the property for support, compromise or waive any  
25 portion of any claim of the state or county for which a person specified under sub. (2)

SENATE BILL 375

1 is liable, but not any claim payable by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or  
2 by any other 3rd party.

3 ~~SECTION 11.~~ 301.12 (14) (a) of the statutes is amended to read:

4 301.12 (14) (a) Except as provided in pars. (b) and (c), liability of a person  
5 specified in sub. (2) or s. 301.03 (18) for care and maintenance of persons under 17  
6 years of age in residential, nonmedical facilities such as group homes, foster homes,  
7 treatment foster homes, child caring institutions, and juvenile correctional  
8 institutions is determined in accordance with the cost-based fee established under  
9 s. 301.03 (18). The department shall bill the liable person up to any amount of  
10 liability not paid by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or by other 3rd-party  
11 benefits, subject to rules which include formulas governing ability to pay  
12 promulgated by the department under s. 301.03 (18). Any liability of the resident not  
13 payable by any other person terminates when the resident reaches age 17, unless the  
14 liable person has prevented payment by any act or omission.

Insert 6-14

15 SECTION 12. 609.60 of the statutes is created to read:

16 ~~609.60~~ Coverage of alcoholism and other diseases. Defined network  
17 plans are subject to s. 632.89.

18 SECTION 13. 632.89 (title) of the statutes is amended to read:

19 ~~632.89 (title) Required coverage of~~ Coverage of mental disorders,  
20 alcoholism, and other diseases.

21 SECTION 14. 632.89 (1) (b) of the statutes is repealed and recreated to read:

22 632.89 (1) (b) "Health benefit plan" has the meaning given in s. 632.745 (11).

23 SECTION 15. 632.89 (1) (em) of the statutes is repealed.

24 SECTION 16. 632.89 (1) (er) of the statutes is created to read:

SECTION #. RC; 632.89(1)(em)



SENATE BILL 375

1

632.89 (1) ~~(a)~~ <sup>em</sup> "Self-insured health plan" has the meaning given in s. 632.745

2

(24).

3

SECTION 17. 632.89 (2) (title) of the statutes is amended to read:

4

632.89 (2) (title) REQUIRED COVERAGE FOR GROUP PLANS.

5

SECTION 18. 632.89 (2) (a) 1. of the statutes is renumbered 632.89 (2) (a) and

6

amended to read:

7

632.89 (2) (a) *Conditions covered.* A group ~~or blanket disability insurance~~ <sup>✓</sup>

8

policy issued by an insurer health benefit plan and a self-insured health plan <sup>✓</sup> shall

9

provide coverage of nervous and mental disorders and alcoholism and other drug

10

abuse problems if required by pars. (c) to (dm) <sup>✓</sup> and as provided in pars. (b) (c) to (e) <sup>✓</sup>

11

(dm) and subs. (2p) and (3). <sup>✓</sup>

12

SECTION 19. 632.89 (2) (a) 2. of the statutes is repealed.

13

SECTION 20. 632.89 (2) (b) of the statutes is repealed.

14

SECTION 21. 632.89 (2) (c) 1. of the statutes is renumbered 632.89 (2) (c) and

15

amended to read:

16

632.89 (2) (c) ~~Minimum coverage~~ Coverage of inpatient hospital services. <sup>✓</sup> If a

17

group ~~or blanket disability insurance policy issued by an insurer~~ health benefit plan

18

or a self-insured health plan <sup>✓</sup> provides coverage of any inpatient hospital treatment,

19

the ~~policy~~ plan <sup>✓</sup> shall provide coverage for inpatient hospital services for the

20

treatment of conditions under par. (a) 1. ~~as provided in subd. 2.~~ <sup>✓</sup>

21

SECTION 22. 632.89 (2) (c) 2. of the statutes is repealed.

22

SECTION 23. 632.89 (2) (d) 1. of the statutes is renumbered 632.89 (2) (d) and

23

amended to read:

24

632.89 (2) (d) ~~Minimum coverage~~ Coverage of outpatient services. <sup>✓</sup> If a group ~~or~~

25

~~blanket disability insurance policy issued by an insurer~~ health benefit plan or a

## SENATE BILL 375

## SECTION 23

1 self-insured health plan provides coverage of any outpatient treatment, the ~~policy~~  
2 plan shall provide coverage for outpatient services for the treatment of conditions  
3 under par. (a) 1. ~~as provided in subd. 2.~~

4 SECTION 24. 632.89 (2) (d) 2. of the statutes is repealed.

5 SECTION 25. 632.89 (2) (dm) 1. of the statutes is renumbered 632.89 (2) (dm)  
6 and amended to read:

7 632.89 (2) (dm) ~~Minimum coverage~~ Coverage of transitional treatment  
8 arrangements. If a group or blanket disability insurance policy issued by an insurer  
9 health benefit plan or a self-insured health plan provides coverage of any inpatient  
10 hospital treatment or any outpatient treatment, the ~~policy plan~~ shall provide  
11 coverage for transitional treatment arrangements for the treatment of conditions  
12 under par. (a) 1. ~~as provided in subd. 2.~~

13 SECTION 26. 632.89 (2) (dm) 2. of the statutes is repealed.

14 SECTION 27. 632.89 (2) (e) of the statutes is renumbered 632.89 (5) (b) and  
15 amended to read:

16 632.89 (5) (b) ~~Exclusion~~ Certain health care plans. This subsection section does  
17 not apply to a health care plan offered by a limited service health organization, as  
18 defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4),  
19 that is not a defined network plan, as defined in s. 609.01 (1b).

20 SECTION 28. 632.89 (2m) of the statutes is renumbered 632.89 (4m).

21 SECTION 29. 632.89 (2p) of the statutes is created to read:

22 632.89 (2p) ADDITIONAL REQUIRED COVERAGE OF SCREENINGS. If a group health  
23 benefit plan, individual health benefit plan, or self-insured health plan that  
24 provides coverage for the treatment of nervous and mental disorders and alcoholism

SENATE BILL 375

1 and other drug abuse problems would provide coverage of at least one annual  
2 physical examination, the plan shall provide coverage of all of the following:

3 (a) For an individual who has coverage under the plan, at least one annual  
4 screening for nervous and mental disorders and alcoholism and other drug abuse  
5 problems to determine the individual's need for treatment.

6 (b) For a female individual who has coverage under the plan, with respect to  
7 any pregnancy at least one screening during the pregnancy for prepartum  
8 depression and at least one screening within 6 months after a live birth, stillbirth,  
9 or miscarriage for postpartum depression to determine the individual's need for  
10 treatment.

Insert 9-12

11 SECTION 30. 632.89 (3) of the statutes is created to read:

12

632.89 (3) EQUAL COVERAGE REQUIREMENT. (a) *Group plans.* A group health  
13 benefit plan or a self-insured health plan that provides coverage for the treatment  
14 of nervous and mental disorders and alcoholism and other drug abuse problems shall  
15 provide the same coverage for that treatment that it provides for the treatment of  
16 physical conditions.

17 (b) *Individual plans.* If an individual health benefit plan provides coverage for  
18 the treatment of nervous or mental disorders or alcoholism or other drug abuse  
19 problems, the individual health benefit plan shall provide the same coverage for that  
20 treatment that it provides for the treatment of physical conditions.

21 (c) *All coverage components.* The requirements under this subsection apply to  
22 all coverage-related components, including rates; exclusions and limitations;  
23 deductibles; copayments; coinsurance; annual and lifetime payment limits;  
24 out-of-pocket limits; out-of-network charges; day, visit, or appointment limits;  
25 duration or frequency of coverage; and medical necessity definitions.



SENATE BILL 375

Subsect 10-1

1 SECTION 31. 632.89 (3m) of the statutes is repealed.

2 SECTION 32. 632.89 (5) (title) of the statutes is amended to read:

3 632.89 (5) (title) ~~MEDICARE EXCLUSION~~ EXCLUSIONS.

4 SECTION 33. 632.89 (5) of the statutes is renumbered 632.89 (5) (a).

5 SECTION 34. 632.89 (5) (a) (title) of the statutes is created to read:

6 632.89 (5) (a) (title) Medicare.

7 SECTION 35. 632.89 (6) of the statutes is repealed.

8 SECTION 36. 632.89 (7) of the statutes is repealed.

9 SECTION 37. Initial applicability.

10 (1) This act first applies to all of the following:

11 (a) Except as provided in paragraphs (b) and (c), health benefit plans that are  
12 issued or renewed, and self-insured governmental health plans that are established,  
13 extended, modified, or renewed, on the effective date of this paragraph.

14 (b) Health benefit plans covering employees who are affected by a collective  
15 bargaining agreement containing provisions inconsistent with this act that are  
16 issued or renewed on the earlier of the following:

- 17 1. The day on which the collective bargaining agreement expires.
- 18 2. The day on which the collective bargaining agreement is extended, modified,  
19 or renewed.

20 (c) Self-insured governmental health plans covering employees who are  
21 affected by a collective bargaining agreement containing provisions inconsistent  
22 with this act that are established, extended, modified, or renewed on the earlier of  
23 the following:

- 24 1. The day on which the collective bargaining agreement expires.

repealed and recreated

Fix component

~~MEDICARE EXCLUSION~~ EXCLUSIONS

NO SCORING

**SENATE BILL 375**

1           2. The day on which the collective bargaining agreement is extended, modified,  
2 or renewed.

3           **SECTION 38. Effective date.**

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

6    (END)

D-note

2009-2010 DRAFTING INSERT  
FROM THE  
LEGISLATIVE REFERENCE BUREAU

LRB-3406/?ins  
PJK:.....

INSERT A

⊗ The bill requires that deductibles, copayments, out-of-pocket limits, and other treatment limitations under a group health benefit plan or a governmental self-insured health plan may not be more restrictive with respect to coverage for the treatment of mental health and substance abuse problems than the most common or frequent type of treatment limitations that apply to substantially all physical condition coverage under the plan. The bill also requires that expenses incurred for the treatment of mental health and substance abuse problems be included in any overall deductible amount under the plan. In addition, the bill requires a group health benefit plan or a governmental self-insured health plan to make available to an insured or plan participant upon request: 1) the plan's criteria for determining medical necessity for coverage for the treatment of and 2) the reason for any denial of coverage for services for the treatment of mental health and substance abuse problems. Current law requires an insurer that restricts or terminates an insured's coverage that results in liability for the insured for the cost of the treatment to provide on the explanation of benefits form an explanation of the clinical rationale for the restriction or termination.

mental health and substance abuse problems

(END OF INSERT A)

the insured's

INSERT 6-14

1 SECTION 1. 40.51 (8) of the statutes, as affected by 2009 Wisconsin Act 28, is  
2 amended to read:

3 40.51 (8) Every health care coverage plan offered by the state under sub. (6)  
4 shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8)  
5 and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to  
6 (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

NOTE: NOTE: Sub. (8) is shown as amended eff. 1-1-10 by 2009 Wis. Act 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets. NOTE:

(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) [s. 632.87 (3) to (6)], 632.895 (5m) and (8) to (15), and 632.896.

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 358; 1987 a. 403 s. 256; 1989 a. 71, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 157, 202, 237, 252; 1999 a. 32, 95, 115, 155; 2001 a. 16, 36, 104; 2003 a. 33; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28

10 SECTION 2. 40.51 (8m) of the statutes, as affected by 2009 Wisconsin Act 28, is  
11 amended to read:

12 40.51 (8m) Every health care coverage plan offered by the group insurance  
13 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,



INS 6-14  
cont

1 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, 632.89, and 632.895  
2 (11) to (17).

NOTE: NOTE: Sub. (8m) is shown as amended eff. 1-1-10 by 2009 Wis. Act 28. Prior to 1-1-10 it reads:NOTE:

3 (8m) Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. ~~632.83, 632.835, 632.85, 632.853, 632.855, and 632.895~~ (1) to (8) and ~~(10), 632.747, 632.748,~~  
4 ~~632.83, 632.835, 632.85, 632.853, 632.855, and 632.895~~ (11) to (15).

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993  
a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 98, 115, 155; 2001 a. 16, 38, 104; 2003 a. 33; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

5 **SECTION 3.** 46.10 (8) (d) of the statutes is amended to read:

6 46.10 (8) (d) After due regard to the case and to a spouse and minor children  
7 who are lawfully dependent on the property for support, compromise or waive any  
8 portion of any claim of the state or county for which a person specified under sub. (2)  
9 is liable, but not any claim payable by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or  
10 by any other 3rd party.

History: 1971 c. 125; 1971 c. 213 s. 5; 1973 c. 90 ss. 223, 223m, 560 (3); 1973 c. 198, 333; 1975 c. 39 ss. 347 to 350, 734; 1975 c. 41, 94; 1975 c. 189 s. 99 (2); 1975 c.  
198, 199, 224; 1975 c. 413 s. 18; 1975 c. 428; 1975 c. 430 ss. 6, 80; 1977 c. 29, 203; 1977 c. 418 ss. 294 to 295, 924 (50), 929 (18); 1977 c. 428; 1977 c. 447 s. 206; 1977 c.  
449 ss. 75, 497; 1979 c. 34; 1979 c. 102 ss. 236 (4), 237; 1979 c. 117, 221, 331; 1981 c. 20 ss. 755 to 758, 2202 (20) (i), (n); 1981 c. 81; 1983 a. 27 ss. 955m, 2202 (20); 1985  
a. 29, 176, 281, 332; 1987 a. 307; 1989 a. 31, 56, 96, 212; 1991 a. 39, 221, 315, 316; 1993 a. 16, 27, 385, 437, 446, 479, 481; 1995 a. 27 ss. 2054, 2055, 9130 (4); 1995 a. 77,  
224, 404; 1997 a. 3, 27, 35, 237, 308; 1999 a. 9, 103; 2001 a. 16, 59, 106; 2003 a. 33; 2005 a. 25, 264, 434; 2007 a. 20, 97; 2009 a. 28.

11 **SECTION 4.** 46.10 (14) (a) of the statutes is amended to read:

12 46.10 (14) (a) Except as provided in pars. (b) and (c), liability of a person  
13 specified in sub. (2) or s. 46.03 (18) for inpatient care and maintenance of persons  
14 under 18 years of age at community mental health centers, a county mental health  
15 complex under s. 51.08, the centers for the developmentally disabled, the Mendota  
16 Mental Health Institute, and the Winnebago Mental Health Institute or care and  
17 maintenance of persons under 18 years of age in residential, nonmedical facilities  
18 such as group homes, foster homes, treatment foster homes, subsidized  
19 guardianship homes, residential care centers for children and youth, and juvenile  
20 correctional institutions is determined in accordance with the cost-based fee  
21 established under s. 46.03 (18). The department shall bill the liable person up to any  
22 amount of liability not paid by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or by other  
23 3rd-party benefits, subject to rules that include formulas governing ability to pay  
24 promulgated by the department under s. 46.03 (18). Any liability of the patient not



INS 6-14  
cont

1 payable by any other person terminates when the patient reaches age 18, unless the  
2 liable person has prevented payment by any act or omission.

NOTE: NOTE: Par. (a) is amended by 2009 Wis. Act 28 eff. the date stated in the notice provided by the secretary of children and families and published in the Wisconsin Administrative Register under s. 48.62 (9) to read:NOTE:

(a) Except as provided in pars. (b) and (c), liability of a person specified in sub. (2) or s. 46.03 (18) for inpatient care and maintenance of persons under 18 years of age at community mental health centers, a county mental health complex under s. 51.08, the centers for the developmentally disabled, the Mendota Mental Health Institute, and the Winnebago Mental Health Institute or care and maintenance of persons under 18 years of age in residential, nonmedical facilities such as group homes, foster homes, subsidized guardianship homes, residential care centers for children and youth, and juvenile correctional institutions is determined in accordance with the cost-based fee established under s. 46.03 (18). The department shall bill the liable person up to any amount of liability not paid by an insurer under s. 632.89 (2) or (2m) or by other 3rd-party benefits, subject to rules that include formulas governing ability to pay promulgated by the department under s. 46.03 (18). Any liability of the patient not payable by any other person terminates when the patient reaches age 18, unless the liable person has prevented payment by any act or omission.

History: 1971 c. 125; 1971 c. 213 s. 5; 1973 c. 90 ss. 223, 223m, 560 (3); 1973 c. 198, 333; 1975 c. 39 ss. 347 to 350, 734; 1975 c. 41, 94; 1975 c. 189 s. 99 (2); 1975 c. 198, 199, 224; 1975 c. 413 s. 18; 1975 c. 428; 1975 c. 430 ss. 6, 80; 1977 c. 29, 203; 1977 c. 418 ss. 294 to 295, 924 (50), 929 (18); 1977 c. 428; 1977 c. 447 s. 206; 1977 c. 449 ss. 75, 497; 1979 c. 34; 1979 c. 102 ss. 236 (4), 237; 1979 c. 117, 221, 331; 1981 c. 20 ss. 755 to 758, 2202 (20) (i), (n); 1981 c. 81; 1983 a. 27 ss. 955m, 2202 (20); 1985 a. 29, 176, 281, 332; 1987 a. 307; 1989 a. 31, 56, 96, 212; 1991 a. 39, 221, 315, 316; 1993 a. 16, 27, 385, 437, 446, 479, 481; 1995 a. 27 ss. 2054, 2055, 9130 (4); 1995 a. 77, 224, 404; 1997 a. 3, 27, 35, 237, 308; 1999 a. 9, 103; 2001 a. 16, 59, 103; 2003 a. 33; 2005 a. 25, 264, 434; 2007 a. 20, 97; 2009 a. 28.

10 SECTION 5. 49.345 (8) (d) of the statutes is amended to read:

11 49.345 (8) (d) After due regard to the case and to a spouse and minor children  
12 who are lawfully dependent on the property for support, compromise or waive any  
13 portion of any claim of the state or county for which a person specified under sub. (2)  
14 is liable, but not any claim payable by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or  
15 by any other 3rd party.

History: 2007 a. 20 ss. 893, 1507; 2009 a. 28.

16 SECTION 6. 49.345 (14) (a) of the statutes is amended to read:

17 49.345 (14) (a) Except as provided in pars. (b) and (c), liability of a person  
18 specified in sub. (2) or s. 49.32 (1) for care and maintenance of persons under 18 years  
19 of age in residential, nonmedical facilities such as group homes, foster homes,  
20 treatment foster homes, subsidized guardianship homes, and residential care  
21 centers for children and youth is determined in accordance with the cost-based fee  
22 established under s. 49.32 (1). The department shall bill the liable person up to any  
23 amount of liability not paid by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or by other  
24 3rd-party benefits, subject to rules that include formulas governing ability to pay  
25 established by the department under s. 49.32 (1). Any liability of the person not  
26 payable by any other person terminates when the person reaches age 18, unless the  
27 liable person has prevented payment by any act or omission.



cont

1 NOTE: NOTE: NOTE: Par. (a) is amended by 2009 Wis. Act 28 eff. the date stated in the notice provided by the secretary of children and families and published  
2 in the Wisconsin Administrative Register under s. 48.62 (9) to read: NOTE:

3 (a) Except as provided in pars. (b) and (c), liability of a person specified in sub. (2) or s. 49.32 (1) for care and maintenance of persons under 18 years of age in  
4 residential, nonmedical facilities such as group homes, foster homes, subsidized guardianship homes, and residential care centers for children and youth is determined  
5 in accordance with the cost-based fee established under s. 49.32 (1). The department shall bill the liable person up to any amount of liability not paid by an insurer  
6 under s. 632.89 (2) or (2m) or by other 3rd-party benefits, subject to rules that include formulas governing ability to pay established by the department under s. 49.32  
7 (1). Any liability of the person not payable by any other person terminates when the person reaches age 18, unless the liable person has prevented payment by any act  
8 or omission.

9 History: 2007 a. 20 ss. 893, 1507; 2009 a. 28.

9 SECTION 7. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28,

10 is amended to read:

11 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or  
12 a village provides health care benefits under its home rule power, or if a town  
13 provides health care benefits, to its officers and employees on a self-insured basis,  
14 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),  
15 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4), (5),  
16 and (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

NOTE: NOTE: Sub. (4) is shown as amended eff. 1-1-10 by 2009 Wis. Act 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in  
brackets. NOTE:

17 (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  
18 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)  
19 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4), and (5) [s. 632.87 (4), (5), and (6)], 632.895 (9) to (17), 632.896, and 767.25 (4m) (d) [s. 767.513 (4)].

History: 1999 a. 9, 115; 1999 a. 150 ss. 34, 303 to 306; Stats. 1999 s. 66.0137; 1999 a. 186 s. 63; 2001 a. 16, 30; 2005 a. 194; 2005 a. 443 s. 265; 2007 a. 20, 36; 2009 a.  
14, 28.

20 SECTION 8. 111.91 (2) (qm) of the statutes is created to read:

21 111.91 (2) (qm) The requirements under s. 632.89 relating to coverage of  
22 screening and treatment for nervous and mental disorders and alcoholism and other  
23 drug problems.

24 SECTION 9. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28,

25 is amended to read:

26 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.  
27 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),  
28 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895 (9) to (17),  
29 632.896, and 767.513 (4).

NOTE: NOTE: Par. (g) is shown as amended eff. 1-1-10 by 2009 Wis. Acts 14 and 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown  
in brackets. NOTE:



1 (g) Every self-insured plan under par. (b) shall comply with ss. 49.403 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (c) 2. and (b) 2., ~~632.747 (3), 632.85, 632.853,~~  
2 ~~632.855, 632.87 (4) and (5) [s. 632.87 (4), (5), and (6)], 632.895 (9) to (15), 632.896, and 767.25 (4m) (a) [s. 767.813 (4)].~~

History: 1975 c. 94, 290; 1975 c. 115, 321; 1977 c. 206, 211, 418, 429; 1979 c. 20, 202, 221, 301, 355; 1981 c. 96, 314, 335; 1983 a. 27, 193, 207, 339, 370, 518, 538; 1985 a. 29 ss. 1725e to 1726m, 1731; 1985 a. 101, 135, 211; 1985 a. 218 ss. 12, 13, 22; 1985 a. 332; 1987 a. 88, 187; 1989 a. 31, 201, 336, 359; 1991 a. 39, 226, 269; 1993 a. 16, 27, 284, 334, 399, 450, 481, 491; 1995 a. 27 ss. 4024, 9126 (19), 9145 (1); 1995 a. 29, 32, 33, 65, 75, 225, 235, 289, 439; 1997 a. 27, 155, 164, 191, 237, 335; 1999 a. 9, 19, 73, 83, 115, 128; 1999 a. 150 s. 672; 1999 a. 186; 2001 a. 38, 98, 103, 105; 2003 a. 254; 2005 a. 22, 194, 290, 346; 2005 a. 443 s. 265; 2007 a. 20 ss. 2738, 9121 (6) (a); 2007 a. 36, 70, 97; 2009 a. 14, 28.

3 SECTION 10. 185.981 (4t) of the statutes, as affected by 2009 Wisconsin Act 28,  
4 is amended to read:

5 185.981 (4t) A sickness care plan operated by a cooperative association is  
6 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85,  
7 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (10) to  
8 (17), and 632.897 (10) and chs. 149 and 155.

NOTE: NOTE: Sub. (4t) is shown as amended eff. 1-1-10 by 2009 Wis. Acts 14 and 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets. NOTE:

9 (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,  
10 632.87 (2m), (3), (4), and (5) [s. 632.87 (2m), (3), (4), (5), and (6)], 632.895 (10) to (15), and 632.897 (10) and chs. 149 and 155.

History: 1971 c. 40 s. 93; 1971 c. 307 s. 118; 1975 c. 98; 1975 c. 223 s. 28; 1975 c. 224 s. 146; 1975 c. 421; 1981 c. 39 s. 22; 1981 c. 205; 1981 c. 391 s. 210; 1985 a. 29; 1985 a. 30 s. 42; 1987 a. 27 ss. 1917e, 3202 (47) (a); 1987 a. 312 s. 17; 1989 a. 121, 129, 200, 201, 336; 1991 a. 39, 123, 269; 1993 a. 27, 450, 481; 1995 a. 27, 118, 289; 1997 a. 27, 155, 237; 1999 a. 95, 115; 2003 a. 321; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

11 SECTION 11. 185.983 (1) (intro.) of the statutes, as affected by 2009 Wisconsin  
12 Act 28, is amended to read:

13 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be  
14 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,  
15 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,  
16 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853,  
17 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (5) and (9) to (17),  
18 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring  
19 association shall:

NOTE: NOTE: Sub. (1) (intro.) is shown as amended eff. 1-1-10 by 2009 Wis. Acts 14 and 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets. NOTE:

20 (1) 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,  
21 601.44, 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),  
22 (3), (4), and (5) [s. 632.87 (2m), (3), (4), (5), and (6)], 632.895 (5) and (9) to (15), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring  
23 association shall:

History: 1975 c. 98; 1975 c. 224 s. 146; 1975 c. 352; 1975 c. 422 s. 163; 1977 c. 339; 1979 c. 89; 1981 c. 20; 1981 c. 39 s. 22; 1981 c. 82; 1981 c. 391 s. 210; 1983 a. 189 s. 329 (25); 1983 a. 396; 1985 a. 29 ss. 2060d to 2060r, 3202 (30); 1987 a. 7, 325; 1989 a. 23, 31, 129, 200, 201, 336, 359; 1991 a. 39, 189, 250, 269, 315; 1993 a. 450, 481, 482; 1995 a. 289; 1997 a. 27, 155, 237; 1999 a. 95, 115; 2003 a. 321; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

24 SECTION 12. 301.12 (8) (d) of the statutes is amended to read:

25 301.12 (8) (d) After due regard to the case and to a spouse and minor children  
26 who are lawfully dependent on the property for support, compromise or waive any



INS 6-14  
CONT

1 portion of any claim of the state or county for which a person specified under sub. (2)  
2 is liable, but not any claim payable by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or  
3 by any other 3rd party.

History: 1995 a. 27 ss. 6361, 9126 (19); 1995 a. 77; 1997 a. 237; 1999 a. 103; 2001 a. 59; 2007 a. 20, 97; 2009 a. 28.

**SECTION 13.** 301.12 (14) (a) of the statutes is amended to read:

5 301.12 (14) (a) Except as provided in pars. (b) and (c), liability of a person  
6 specified in sub. (2) or s. 301.03 (18) for care and maintenance of persons under 17  
7 years of age in residential, nonmedical facilities such as group homes, foster homes,  
8 treatment foster homes, residential care centers for children and youth and juvenile  
9 correctional institutions is determined in accordance with the cost-based fee  
10 established under s. 301.03 (18). The department shall bill the liable person up to  
11 any amount of liability not paid by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or by  
12 other 3rd-party benefits, subject to rules which include formulas governing ability  
13 to pay promulgated by the department under s. 301.03 (18). Any liability of the  
14 resident not payable by any other person terminates when the resident reaches age  
15 17, unless the liable person has prevented payment by any act or omission.

NOTE: NOTE: Par. (a) is amended by 2009 Wis. Act 28 eff. the date stated in the notice provided by the secretary of children and families and published in the Wisconsin Administrative Register under s. 48.62 (9) to read:NOTE:

16 (a) Except as provided in pars. (b) and (c), liability of a person specified in sub. (2) or s. 301.03 (18) for care and maintenance of persons under 17 years of age in  
17 residential, nonmedical facilities such as group homes, foster homes, residential care centers for children and youth, and juvenile correctional institutions is determined  
18 in accordance with the cost-based fee established under s. 301.03 (18). The department shall bill the liable person up to any amount of liability not paid by an insurer  
19 under s. 632.89 (2) or ~~(2m)~~ or by other 3rd-party benefits, subject to rules that include formulas governing ability to pay promulgated by the department under s. 301.03  
20 (18). Any liability of the resident not payable by any other person terminates when the resident reaches age 17, unless the liable person has prevented payment by any  
21 act or omission.

History: 1995 a. 27 ss. 6361, 9126 (19); 1995 a. 77; 1997 a. 237; 1999 a. 103; 2001 a. 59; 2007 a. 20, 97; 2009 a. 28.

(END OF INSERT 6-14)

INSERT 9-12

22 WORK LIMITATIONS. ✓ The exclusions and limitations; deductibles; ✓ copayments;  
23 coinsurance; annual and lifetime payment limitations; ✓ out-of-pocket limits;  
24 out-of-network charges; day, visit, or appointment limits; and ✓ duration or frequency  
25 of coverage limits under a group health benefit plan ✓ or a self-insured health plan ✓





1 may be no more restrictive for the coverage required under this section<sup>✓</sup> than the most  
2 common or frequent type of treatment limitations applied to substantially all  
3 physical condition coverage under the plan.<sup>✓</sup> The plan shall include in any overall  
4 deductible amount for the plan, expenses incurred for the treatment of nervous and  
5 mental disorders and alcoholism<sup>✓</sup> and other drug abuse problems and for the  
6 screening required under sub. (2p).<sup>✓</sup>

(END OF INSERT 9-12)

**INSERT 10-1**

7 **SECTION 14.** 632.89 (3p)<sup>✓</sup> of the statutes is created to read:  
8 632.89 (3p) AVAILABILITY OF PLAN INFORMATION.<sup>✓</sup> A group health benefit plan and  
9 a self-insured health plan<sup>✓</sup> shall, upon request, make available to any current or  
10 potential<sup>✓</sup> insured, participant, beneficiary, or contracting provider<sup>✓</sup> the criteria for  
11 determining medical necessity under the plan with respect to coverage for the  
12 treatment of nervous or mental disorders and alcoholism and other drug abuse  
13 problems.<sup>✓</sup> If a group health benefit plan or a self-insured health plan denies any  
14 particular insured, participant, or beneficiary coverage for services for the treatment  
15 of nervous or mental disorders or alcoholism or other drug abuse problems,<sup>✓</sup> the plan  
16 shall, upon request, make the reason for the denial available to the insured,  
17 participant, or beneficiary,<sup>✓</sup> in addition to complying with s. 632.857, if applicable.

(END OF INSERT 10-1)

**DRAFTER'S NOTE  
FROM THE  
LEGISLATIVE REFERENCE BUREAU**

*date*

LRB-3406/2dn

PJK:.....

*Jld*

*in current law*

Section 632.857 requires an insurer to provide an explanation of benefits for the reason for a coverage restriction or termination. See how I have drafted the second sentence of proposed s. 632.89 (3p) (which is arguably redundant to s. 632.857) to coordinate with this provision. Is this okay or would you like something different?

Note that I required expenses incurred for the screening required under the bill to be included in the overall deductible under proposed s. 632.89 (3). Is this okay?

Do you want proposed s. 632.89 (3) and (3p) to apply to individual health benefit plans, too? Note that, under the bill, only group health benefit plans are required to provide the coverage. However, an individual health benefit plan may provide the coverage even if not required to do so.

Pamela J. Kahler  
Senior Legislative Attorney  
Phone: (608) 266-2682  
E-mail: pam.kahler@legis.wisconsin.gov

**DRAFTER'S NOTE  
FROM THE  
LEGISLATIVE REFERENCE BUREAU**

LRB-3406/P1dn  
PJK:jld:ph

September 15, 2009

Section 632.857 in current law requires an insurer to provide on an explanation of benefits form the reason for a coverage restriction or termination. See how I have drafted the second sentence of proposed s. 632.89 (3p) (which is arguably redundant to s. 632.857) to coordinate with this provision. Is this okay or would you like something different?

Note that I required expenses incurred for the screening required under the bill to be included in the overall deductible under proposed s. 632.89 (3). Is this okay?

Do you want proposed s. 632.89 (3) and (3p) to apply to individual health benefit plans, too? Note that, under the bill, only group health benefit plans are required to provide the coverage. However, an individual health benefit plan may provide the coverage even if not required to do so.

Pamela J. Kahler  
Senior Legislative Attorney  
Phone: (608) 266-2682  
E-mail: [pam.kahler@legis.wisconsin.gov](mailto:pam.kahler@legis.wisconsin.gov)

**Kahler, Pam**

---

**From:** Ludwig, Frederic  
**Sent:** Wednesday, September 16, 2009 2:47 PM  
**To:** Kahler, Pam  
**Subject:** re: parity

Pam,

In response to your question re: whether or not the bill should apply to individual health benefit plans, the answer is yes. However, we would like it to mirror the language in the 2007 bill (does not require individual plans to cover mental health/substance abuse problems, but must provide the same coverage for mental conditions as it does for physical conditions if it covers mental conditions). I'll get back to you on your other two questions, but thought I'd just forward this along sooner than later.

Fred

*per Fred by phone 9-18*

*to include individual  
plans that do provide*

*the coverage in  
subs (3) & (3p).*

—  
Fred Ludwig  
**Office of Representative Sandy Pasch**  
608.266.7671 (Office)  
888.534.0022 (Toll-free)  
608.282.3622 (Fax)

**Kahler, Pam**

---

**From:** Ludwig, Frederic  
**Sent:** Thursday, September 17, 2009 11:22 AM  
**To:** Kahler, Pam  
**Subject:** re: parity

In response to your other two questions:

- We are wondering whether the response to 632.857 is an EOB that says "not medically necessary". If so, this would need to be changed (and is arguably not in compliance with statute because it is not a detailed explanation of rationale or policy). In that case we would rather see the language in 632.89 (3p) specifically say:

...the plan shall, upon request, document how the requested service fails to meet the criteria for medical necessity identified in this section and make this information available to....

*ok to leave as is per Duke Sweet*

- The language on incurred expenses for screenings under s. 632.89(3) is fine.

--

Fred Ludwig  
**Office of Representative Sandy Pasch**  
608.266.7671 (Office)  
888.534.0022 (Toll-free)  
608.282.3622 (Fax)

---

**From:** Ludwig, Frederic  
**Sent:** Wednesday, September 16, 2009 2:47 PM  
**To:** Kahler, Pam  
**Subject:** re: parity

Pam,

In response to your question re: whether or not the bill should apply to individual health benefit plans, the answer is yes. However, we would like it to mirror the language in the 2007 bill (does not require individual plans to cover mental health/substance abuse problems, but must provide the same coverage for mental conditions as it does for physical conditions if it covers mental conditions). I'll get back to you on your other two questions, but thought I'd just forward this along sooner than later.

Fred

--

Fred Ludwig  
**Office of Representative Sandy Pasch**  
608.266.7671 (Office)  
888.534.0022 (Toll-free)  
608.282.3622 (Fax)

## Kahler, Pam

---

**From:** Kahler, Pam  
**Sent:** Monday, September 21, 2009 4:03 PM  
**To:** Ludwig, Frederic  
**Cc:** Sweet, Richard  
**Subject:** Parity bill draft

Hi, Fred:

I talked to Debra Kraft about the issue in my first drafter's note, and she also thought the language that had been suggested for the draft was probably not necessary because of s. 632.857 in current law, but she suggested that I call Dick Sweet. I just spoke with Dick. He agrees that s. 632.857 already does what the suggested language for the second sentence of proposed s. 632.89 (3p) does, but he doesn't see a problem with keeping what I've drafted in the bill.

I've made the other changes and will get a P2 out to you shortly. If anyone else has a problem with the way I have drafted proposed s. 632.89 (3p), we can take care of it in a later version.

Pam

*Pamela J. Kahler*  
*Legislative Attorney*  
*Legislative Reference Bureau*  
608-266-2682