State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3406/P1
PJK:jld:nh

P2

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PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

(i- 9-21)

Regen

AN ACT ***to repeal*** 632.89 (2) (a) 2., 632.89 (2) (b), 632.89 (2) (c) 2., 632.89 (2) (d) 2., 632.89 (2) (dm) 2., 632.89 (3m), 632.89 (6) and 632.89 (7); ***to renumber*** 632.89 (2m) and 632.89 (5); ***to renumber and amend*** 632.89 (2) (a) 1., 632.89 (2) (c) 1., 632.89 (2) (d) 1., 632.89 (2) (dm) 1. and 632.89 (2) (e); ***to amend*** 40.51 (8), 40.51 (8m), 46.10 (8) (d), 46.10 (14) (a), 49.345 (8) (d), 49.345 (14) (a), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 301.12 (8) (d), 301.12 (14) (a), 632.89 (title) and 632.89 (2) (title); ***to repeal and recreate*** 632.89 (1) (b), 632.89 (1) (em) and 632.89 (5) (title); and ***to create*** 111.91 (2) (qm), 609.71, 632.89 (2p), 632.89 (3), 632.89 (3p) and 632.89 (5) (a) (title) of the statutes; **relating to:** health insurance coverage of 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 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.

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 governmental self-insured health plans of the state and municipalities. In addition, the bill requires group and individual health benefit plans and governmental self-insured health 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 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 mental health and substance abuse problems; 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 the insured's liability 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 of coverage.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

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

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

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

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, 632.89, and 632.895 (11) to (17).

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

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

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

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

46.10 **(14)** (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, treatment 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)~~ (4m) 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.

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

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

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

49.345 **(14)** (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 residential, nonmedical facilities such as group homes, foster homes, treatment foster homes, subsidized guardianship homes, and residential care centers for children and youth is determined 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 under s. 632.89 (2) or ~~(2m)~~ (4m) or by other 3rd-party benefits, subject to rules that include formulas governing ability to pay established by the department under s. 49.32 (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 or omission.

SECTION 7. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

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

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

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

SECTION 9. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

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

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

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

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

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

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

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

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

301.12 **(14)** (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 residential, nonmedical facilities such as group homes, foster homes, treatment foster homes, residential care centers for children and youth and juvenile correctional institutions is determined 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 under s. 632.89 (2) or ~~(2m)~~ (4m) or by other 3rd-party benefits, subject to rules which include formulas governing ability to pay promulgated by the department under s. 301.03 (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 act or omission.

SECTION 14. 609.71 of the statutes is created to read:

609.71 Coverage of alcoholism and other diseases. Defined network plans are subject to s. 632.89.

SECTION 15. 632.89 (title) of the statutes is amended to read:

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

SECTION 16. 632.89 (1) (b) of the statutes is repealed and recreated to read:

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

SECTION 17. 632.89 (1) (em) of the statutes is repealed and recreated to read:.

632.89 **(1)** (em) "Self-insured health plan" has the meaning given in s. 632.745 (24).

SECTION 18. 632.89 (2) (title) of the statutes is amended to read:

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

SECTION 19. 632.89 (2) (a) 1. of the statutes is renumbered 632.89 (2) (a) and amended to read:

632.89 **(2)** (a) *Conditions covered.* A group ~~or blanket disability insurance policy issued by an insurer~~ health benefit plan and a self-insured health plan shall provide coverage of nervous and mental disorders and alcoholism and other drug abuse problems if required by pars. (c) to (dm) and as provided in pars. ~~(b)~~ (c) to ~~(e)~~ (dm) and subs. (2p) and (3).

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

SECTION 21. 632.89 (2) (b) of the statutes is repealed.

SECTION 22. 632.89 (2) (c) 1. of the statutes is renumbered 632.89 (2) (c) and amended to read:

632.89 **(2)** (c) ~~*Minimum coverage*~~ *Coverage of inpatient hospital services.* If a group ~~or blanket disability insurance policy issued by an insurer~~ health benefit plan or a self-insured health plan provides coverage of any inpatient hospital treatment, the ~~policy~~ plan shall provide coverage for inpatient hospital services for the treatment of conditions under par. (a) ~~1. as provided in subd. 2~~.

SECTION 23. 632.89 (2) (c) 2. of the statutes is repealed.

SECTION 24. 632.89 (2) (d) 1. of the statutes is renumbered 632.89 (2) (d) and amended to read:

632.89 **(2)** (d) ~~*Minimum coverage*~~ *Coverage of outpatient services.* If a group ~~or blanket disability insurance policy issued by an insurer~~ health benefit plan or a self-insured health plan provides coverage of any outpatient treatment, the ~~policy~~ plan shall provide coverage for outpatient services for the treatment of conditions under par. (a) ~~1. as provided in subd. 2~~.

SECTION 25. 632.89 (2) (d) 2. of the statutes is repealed.

SECTION 26. 632.89 (2) (dm) 1. of the statutes is renumbered 632.89 (2) (dm) and amended to read:

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

SECTION 27. 632.89 (2) (dm) 2. of the statutes is repealed.

SECTION 28. 632.89 (2) (e) of the statutes is renumbered 632.89 (5) (b) and amended to read:

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

SECTION 29. 632.89 (2m) of the statutes is renumbered 632.89 (4m).

SECTION 30. 632.89 (2p) of the statutes is created to read:

632.89 **(2p)** ADDITIONAL REQUIRED COVERAGE OF SCREENINGS. If a group health benefit plan, individual health benefit plan, or self-insured health plan that provides coverage for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems would provide coverage of at least one annual physical examination, the plan shall provide coverage of all of the following:

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

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

Insert 10-7

SECTION 31. 632.89 (3) of the statutes is created to read:

632.89 **(3)** LIMITATIONS. The exclusions and limitations; deductibles; copayments; coinsurance; annual and lifetime payment limitations; out-of-pocket limits; out-of-network charges; day, visit, or appointment limits; and duration or frequency of coverage limits under a group health benefit plan or a self-insured health plan may be no more restrictive for the coverage required under this section than the most common or frequent type of 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 the treatment of nervous and mental disorders and alcoholism and other drug abuse problems and for the screening required under sub. (2p).

Insert 10-11

SECTION 32. 632.89 (3m) of the statutes is repealed.

SECTION 33. 632.89 (3p) of the statutes is created to read:

632.89 **(3p)** AVAILABILITY OF PLAN INFORMATION. A group health benefit plan and a self-insured health plan shall, upon request, make available to any current or potential insured, participant, beneficiary, or contracting provider the criteria for determining medical necessity under the plan with respect to coverage for the treatment of nervous or mental disorders and alcoholism and other drug abuse problems. If a group health benefit plan or a self-insured health plan denies any particular insured, participant, or beneficiary coverage for services for the treatment that provides coverage

Insert 10-11

(individual health benefit plan)

of nervous or mental disorders or alcoholism or other drug abuse problems, the plan shall, upon request, make the reason for the denial available to the insured, participant, or beneficiary, in addition to complying with s. 632.857, if applicable.

SECTION 34. 632.89 (5) (title) of the statutes is repealed and recreated to read:

632.89 **(5)** (title) EXCLUSIONS.

SECTION 35. 632.89 (5) of the statutes is renumbered 632.89 (5) (a).

SECTION 36. 632.89 (5) (a) (title) of the statutes is created to read:

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

SECTION 37. 632.89 (6) of the statutes is repealed.

SECTION 38. 632.89 (7) of the statutes is repealed.

SECTION 39. Initial applicability.

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

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

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

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

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

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

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

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

SECTION 40. Effective date.

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

(END)

INSERT 10-7

For a group health benefit plan and a self-insured health plan, and for an individual health benefit plan that provides coverage for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems,

(END OF INSERT 10-7)

INSERT 10-11

of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems

(END OF INSERT 10-11)

TO: Fred Ludwig,
Office of Representative Sandra Pasch

FROM: David Riemer & Debra Kraft
Community Advocates Public Policy Institute

DATE: September 22, 2009

RE: Questions and Comments Regarding LRB-3406/P2

1. P. 9, line 15-18. **SECTION 28**

   We assume that the intent of the legislation is to apply to all group health benefit plans, i.e., Fee-for-Service plans, Preferred Provider plans, Defined Network plans, and HMO plans. However, **SECTION 28** on p. 9, lines 15-18, excludes not only a "limited service health organization" but also a "preferred provider plan...that is not a defined network plan." We are not sure how many preferred provider plans (PPP) do not fall within the definition of a "defined network plan". But even if some PPPs are not "defined network plans," we don't understand the reason for excluding this type of PPP from the new mandate to provide full & parity benefits for mental disorders, alcoholism and other drug addictions. Isn't it preferable to capture all PPPs, as well as FFS, HMO and Defined Network plans with this legislation? includes PPP's that offer limited benefits

2. P. 10, lines 10-22. **SECTION 31**

   a. It may be helpful on lines 10-11 to define a "self-insured health plan" as being a "self-insured health plan as defined in s. 632.89(1)(em). This will avoid any confusion that the legislation is trying to impose a mandate on self-insured plans in general. doesn't work that way

   b. On line 12, we believe that "and" should be changed to "or" in each of the three instances where "and" is used, in order to ensure that the proposed legislation's parity requirement for individual insurance applies to all individual health benefit plans that have either a mental disorder OR an alcohol/other drug addiction benefit. Since coverage is not mandated for individual plans, it would be regrettable if—when an individual chooses to buy a plan that has ONLY mental or ONLY alcohol/other drug addiction coverage—parity would fail to apply to the coverage the individual has purchased. Replacing "and" with "or" should solve this problem.

   c. On lines 17, and 20-21, same comment and recommendation as above. If you agree with the change that we have recommended for the individual plan coverage above, then we suggest making these revisions in order to

ensure that parity will apply to both individual and group health insurance.

d. On line 19, "physical condition coverage" is an undefined term that could be interpreted in many ways, resulting in confusion or determinations of inapplicability of coverage by the plans. We don't yet have a specific alternative to suggest, but believe this warrants further discussion.

e. On lines 19-22, we suggest that the reference to cost-sharing mention not only "deductible" but also "co-pay, co-insurance, and annual or lifetime out-of-pocket maximums" to ensure that there are no separate cost-sharing requirements for mental/alcohol/other drug treatments.

f. For lines 13-16, we suggest that there be specific inclusion of a new parity requirement that referrals to and treatment by non-physician providers and programs shall be no more restrictive for mental/alcohol/other drug treatments than the health benefit plan's policies relating to referrals to and treatment by non-physician providers and programs in the case of "physical condition coverage" (which still should be more clearly defined). This is implicit in the parity requirements for "exclusions and limitations", but it is such a critical issue that it would be desirable to be specific. We suggest adding in lines 13-16: "referrals to and treatment by non-physician providers and programs;" as one of the categories under the plan that are no more restrictive for coverage of the treatment of nervous or mental disorders or alcoholism or other drug abuse problems than the most common or frequent type of treatment limitations applied to substantially all "physical condition" coverage under the plan.

Kahler, Pam

From: Ludwig, Frederic
Sent: Wednesday, September 23, 2009 11:50 AM
To: Sweet, Richard
Cc: Kahler, Pam
Subject: RE: updated parity draft

Would 2 work for you?

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

From: Sweet, Richard
Sent: Wednesday, September 23, 2009 11:41 AM
To: Ludwig, Frederic; Kahler, Pam
Subject: RE: updated parity draft

Fred, I'm fine with talking to everyone. It probably makes sense for Pam and I to be together in one office on speaker-phone (we can use my office if Pam's okay with that), rather than try to transmit changes to Pam afterwards. I'm actually pretty open this afternoon and tomorrow.

Fred, do you want to be in on the call? I would hate to make any decisions without your involvement.

Dick

From: Ludwig, Frederic
Sent: Wednesday, September 23, 2009 11:30 AM
To: Kahler, Pam; Sweet, Richard
Subject: FW: updated parity draft

If neither of you mind, I think it would be easiest to allow Shel, David, and Debra to contact you regarding questions/concerns/changes to the draft (see below). Our office is getting pretty hectic, and I obviously don't want that to impede on deliberation surrounding the legislation. Let me know if you have any concerns regarding this or if you are OK with them contacting you.

Thanks,
Fred

--
Fred Ludwig

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

From: Debra Kraft [mailto:debrak@communityadvocates.net]
Sent: Wednesday, September 23, 2009 11:22 AM
To: Ludwig, Frederic; Shel Gross
Cc: David Riemer
Subject: RE: updated parity draft

Yes, David and I will be available at 2:00. Shel – does that work for you?

Then, Fred, are you suggesting that we call Pam and Dick – and if so, will you have called them first to let them know that we have your permission to speak with them?

Deb

Debra J. Kraft
Deputy Director and Counsel
Community Advocates, Inc. Public Policy Institute
744 North 4th Street, Suite 200
Milwaukee, WI 53203
p: 414.270.2944
f: 414.270.2971
Email: debrak@communityadvocates.net
www.ca-ppi.org

From: Ludwig, Frederic [mailto:Frederic.Ludwig@legis.wisconsin.gov]
Sent: Wednesday, September 23, 2009 11:15 AM
To: Debra Kraft; Shel Gross
Cc: David Riemer
Subject: RE: updated parity draft

Would the three of you have time to discuss the changes today? Rep. Pasch and myself will be tied up in meetings and other obligations for most of the day, so for the sake of getting changes/concerns addressed in a timely manner, I think it would be most effective if you're able to chat and forward along your recommendations for changes. From there, it might not be a bad idea to then discuss directly with Pam (drafter) or Dick (Leg Council).

--

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

From: Debra Kraft [mailto:debrak@communityadvocates.net]
Sent: Wednesday, September 23, 2009 10:43 AM
To: Shel Gross; Ludwig, Frederic
Cc: David Riemer
Subject: RE: updated parity draft

Hi, Shel and Fred:

I'm thinking that we all should discuss rather than do this via emails. However ... some quick thoughts to Shel's points:

2 c. The reason that we included "or" vs "and" is to capture the individual plans that are not mandated to have coverage, and to tie in the changes that we suggested for Section 31, line 12 (our memo comment 2. b.) so that those individual plans that do not, as an example, choose to offer MH, but do choose to offer addiction, or vice versa, would be bond by this provision. Without using "or" in this sentence, the only individual plans that will be included will be those that offer both MH and addiction.

I would argue that using "or" does not exclude including deductible amounts for MH and addiction.

2. d. The term "physical condition" does not derive from the federal Wellstone-Domenici law. I agree that the federal regs should clarify what "medical/surgical" (the term used in the federal legislation as the basis for comparison with MH/addiction benefits) means and that the state language should piggyback accordingly. However, this is a timing issue at the moment since we don't know when the federal regs will be issued – although we're hopeful that it will be sometime in the middle of October. Accordingly, we should discuss the use of "physical condition" and whether a more clearly defined term (such as the use of the federal term?) may be preferable.

2. f. I'd like to suggest that we discuss this point as well. We would like to ensure that "parity" includes those situations wherein a physician refers a patient to a non-physician provider or treatment program for treatment; and that a patient may opt to be treated by a non-physician provider (i.e., licensed mental health professionals as defined in s. 632.89(1)(dm) and licensed psycologists) without a physician referral (which is clearly provided for in the recently enacted state Medicaid statute Wis. Stat. 49.45 (30f) *Psychotherapy and alcohol and other drug abuse services.*

Please let me know how you would like to proceed.

Deb

Debra J. Kraft
Deputy Director and Counsel
Community Advocates, Inc. Public Policy Institute
744 North 4th Street, Suite 200
Milwaukee, WI 53203
p: 414.270.2944
f: 414.270.2971
Email: debrak@communityadvocates.net
www.ca-ppi.org

From: Shel Gross [mailto:shelgross@tds.net]
Sent: Wednesday, September 23, 2009 10:20 AM
To: 'Ludwig, Frederic'
Cc: Debra Kraft
Subject: RE: updated parity draft

1. With regard to Sec. 28 I don't believe this has changed from previous drafts so I'm not sure what the original rationale was. Someone should respond to the question.
2. a. This makes sense. We asked that you take the language from the federal legislation, but that has a reach beyond what the state legislation has.
   b. I think the idea is a good one. I don't suppose "and/or" is allowed in statutes?
   c. I'm not sure the same thinking applies to lines 20-21. To me that would imply that a plan that covers both mental illness and substance abuse can decide to count one or the other towards the deductible and not both.
   d. This is taken from the federal bill. So, yes, it is unclear although it may be clarified in federal regulations. I'm concerned about us defining it differently than the way the feds do.
   e. We added this section because there was already talk of separate deductibles as a way of continuing to discriminate against these disorders. Although some people think the federal clearly would not allow this we thought it prudent to add. It does not make sense to add co-pays or co-insurance to this (I think) because there will be separate co-payments or coinsurance for these services but the section preceding already makes it clear that these cannot be more restrictive than for other physical conditions. However, adding annual and lifetime limits would make sense in the same way that addressing deductibles does.
   f. I would want further clarification on exactly what sort of situations would be implied by saying that referrals are no more restrictive.

I am always reminded of something someone told me when I first started working for the state: you can't come up with a system that someone won't figure out how to game. We should try, but… I heard from a psychotherapist friend of mine that one of the HMOs in Madison has already announced that they will be charging $50 copays for psychotherapy services. Apparently this is their usual copay for being seen by a specialist. It is not clear to me whether they charge that for all specialists or some. But obviously a $50 copay for specialist who you see 2 or 3 times is quite different than the same copay for a specialist you see 20 times. Now why didn't I anticipate that?

Shel Gross
Mental Health America of Wisconsin

From: Ludwig, Frederic [mailto:Frederic.Ludwig@legis.wisconsin.gov]
Sent: Tuesday, September 22, 2009 5:12 PM
To: shelgross@tds.net
Subject: FW: updated parity draft

FYI. Thought it might be a good idea to get your thoughts on this.

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

From: Debra Kraft [mailto:debrak@communityadvocates.net]
Sent: Tuesday, September 22, 2009 5:07 PM
To: Ludwig, Frederic; shelgross@tds.net; marcherstand@tds.net; David Riemer
Subject: RE: updated parity draft

Hi, Fred:

As you requested, we have attached a memo that contains our comments to the revised draft of LRB-3406/P2 that can be used in a further discussion with Pam and Dick. We've not had a lot of time to review the draft, but wanted to turn this around quickly for you. That said, going forward, and if ok with you, we may be providing you with additional thoughts as we continue to take a more in-depth look at the language. Of course, we would be happy to talk with Pam and Dick at their convenience if you all would find that to be helpful.

Thank you for the opportunity to weigh in on this very important matter.

Deb

Debra J. Kraft
Deputy Director and Counsel
Community Advocates, Inc. Public Policy Institute
744 North 4th Street, Suite 200
Milwaukee, WI 53203
p: 414.270.2944
f: 414.270.2971
Email: debrak@communityadvocates.net
www.ca-ppi.org

From: Ludwig, Frederic [mailto:Frederic.Ludwig@legis.wisconsin.gov]
Sent: Tuesday, September 22, 2009 1:08 PM
To: Debra Kraft; shelgross@tds.net; marcherstand@tds.net; David Riemer
Subject: re: updated parity draft

Just received the updated draft. Take a look and let me know what you think.

--

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

9-23 conference call

yes ✓ physical condition coverage → other coverage

yes add: payment limits, out-of-pocket limits to overall amount in (3) second sentence

add: ~~to~~ list in sub. (3) or referrals to and treatment by non-physician providers & programs

referrals to & treatment coverage of outpatient & transitional inpatient

at end of line 15 after limits on line 16

referral & treatment to and treated

yes * limitations ~~referrals~~ regarding referrals to non-physicians ~~providers~~ providers

* limitations regarding referrals to outpat. sltx or tran. treat arrangements

define non-physician provider as (1)(e) 1., 3., 4.

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3406/P1
PJK:jld:ph

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ***to repeal*** 632.89 (2) (a) 2., 632.89 (2) (b), 632.89 (2) (c) 2., 632.89 (2) (d) 2., 632.89 (2) (dm) 2., 632.89 (3m), 632.89 (6) and 632.89 (7); ***to renumber*** 632.89 (2m) and 632.89 (5); ***to renumber and amend*** 632.89 (2) (a) 1., 632.89 (2) (c) 1., 632.89 (2) (d) 1., 632.89 (2) (dm) 1. and 632.89 (2) (e); ***to amend*** 40.51 (8), 40.51 (8m), 46.10 (8) (d), 46.10 (14) (a), 49.345 (8) (d), 49.345 (14) (a), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 301.12 (8) (d), 301.12 (14) (a), 632.89 (title) and 632.89 (2) (title); ***to repeal and recreate*** 632.89 (1) (b), 632.89 (1) (em) and 632.89 (5) (title); and ***to create*** 111.91 (2) (qm), 609.71, 632.89 (2p), 632.89 (3), 632.89 (3p) and 632.89 (5) (a) (title) of the statutes; **relating to:** health insurance coverage of 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 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.

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 governmental self-insured health plans of the state and municipalities. In addition, the bill requires group and individual health benefit plans and governmental self-insured health 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 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, or under an individual health benefit plan that provides coverage of treatment for mental health and substance abuse problems, 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, or an individual health benefit plan that provides coverage of treatment for mental health and substance abuse problems, 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 mental health and substance abuse problems; 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 the insured's liability 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 of coverage.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

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

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

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

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, 632.89, and 632.895 (11) to (17).

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

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

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

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

46.10 **(14)** (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, treatment 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)~~ (4m) 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.

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

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

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

49.345 **(14)** (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 residential, nonmedical facilities such as group homes, foster homes, treatment foster homes, subsidized guardianship homes, and residential care centers for children and youth is determined 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 under s. 632.89 (2) or ~~(2m)~~ (4m) or by other 3rd-party benefits, subject to rules that include formulas governing ability to pay established by the department under s. 49.32 (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 or omission.

SECTION 7. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

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

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

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

SECTION 9. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

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

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

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

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

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

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

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

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

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

301.12 **(14)** (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 residential, nonmedical facilities such as group homes, foster homes, treatment foster homes, residential care centers for children and youth and juvenile correctional institutions is determined 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 under s. 632.89 (2) or ~~(2m)~~ (4m) or by other 3rd-party benefits, subject to rules which include formulas governing ability to pay promulgated by the department under s. 301.03 (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 act or omission.

SECTION 14. 609.71 of the statutes is created to read:

609.71 Coverage of alcoholism and other diseases. Defined network plans are subject to s. 632.89.

SECTION 15. 632.89 (title) of the statutes is amended to read:

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

SECTION 16. 632.89 (1) (b) of the statutes is repealed and recreated to read:

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

SECTION 17. 632.89 (1) (em) of the statutes is repealed and recreated to read:.

632.89 **(1)** (em) "Self-insured health plan" has the meaning given in s. 632.745 (24).

SECTION 18. 632.89 (2) (title) of the statutes is amended to read:

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

SECTION 19. 632.89 (2) (a) 1. of the statutes is renumbered 632.89 (2) (a) and amended to read:

632.89 **(2)** (a) *Conditions covered.* A group ~~or blanket disability insurance policy issued by an insurer~~ health benefit plan and a self-insured health plan shall provide coverage of nervous and mental disorders and alcoholism and other drug abuse problems if required by pars. (c) to (dm) and as provided in pars. ~~(b)~~ (c) to ~~(e)~~ (dm) and subs. (2p) and (3).

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

SECTION 21. 632.89 (2) (b) of the statutes is repealed.

SECTION 22. 632.89 (2) (c) 1. of the statutes is renumbered 632.89 (2) (c) and amended to read:

632.89 **(2)** (c) ~~*Minimum coverage*~~ *Coverage of inpatient hospital services.* If a group ~~or blanket disability insurance policy issued by an insurer~~ health benefit plan or a self-insured health plan provides coverage of any inpatient hospital treatment, the ~~policy~~ plan shall provide coverage for inpatient hospital services for the treatment of conditions under par. (a) ~~1. as provided in subd. 2~~.

SECTION 23. 632.89 (2) (c) 2. of the statutes is repealed.

SECTION 24. 632.89 (2) (d) 1. of the statutes is renumbered 632.89 (2) (d) and amended to read:

632.89 **(2)** (d) ~~*Minimum coverage*~~ *Coverage of outpatient services.* If a group ~~or blanket disability insurance policy issued by an insurer~~ health benefit plan or a self-insured health plan provides coverage of any outpatient treatment, the ~~policy~~

plan shall provide coverage for outpatient services for the treatment of conditions under par. (a) ~~1. as provided in subd. 2~~.

SECTION 25. 632.89 (2) (d) 2. of the statutes is repealed.

SECTION 26. 632.89 (2) (dm) 1. of the statutes is renumbered 632.89 (2) (dm) and amended to read:

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

SECTION 27. 632.89 (2) (dm) 2. of the statutes is repealed.

SECTION 28. 632.89 (2) (e) of the statutes is renumbered 632.89 (5) (b) and amended to read:

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

SECTION 29. 632.89 (2m) of the statutes is renumbered 632.89 (4m).

SECTION 30. 632.89 (2p) of the statutes is created to read:

632.89 **(2p)** ADDITIONAL REQUIRED COVERAGE OF SCREENINGS. If a group health benefit plan, individual health benefit plan, or self-insured health plan that provides coverage for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems would provide coverage of at least one annual physical examination, the plan shall provide coverage of all of the following:

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

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

SECTION 31. 632.89 (3) of the statutes is created to read:

632.89 **(3)** LIMITATIONS. For a group health benefit plan and a self-insured health plan, and for an individual health benefit plan that provides coverage for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems, the exclusions and limitations; deductibles; copayments; coinsurance; annual and lifetime payment limitations; out-of-pocket limits; out-of-network charges; day, visit, or appointment limits; and duration or frequency of coverage limits under the plan may be no more restrictive for coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems than the most common or frequent type of 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 the treatment of nervous and mental disorders and alcoholism and other drug abuse problems and for the screening required under sub. (2p).

SECTION 32. 632.89 (3m) of the statutes is repealed.

SECTION 33. 632.89 (3p) of the statutes is created to read:

632.89 **(3p)** AVAILABILITY OF PLAN INFORMATION. A group health benefit plan, individual health benefit plan, and self-insured health plan that provides coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems shall, upon request, make available to any current or potential insured, participant, beneficiary, or contracting provider the criteria for determining medical necessity under the plan with respect to that coverage. If a group health benefit plan, individual health benefit plan, or self-insured health plan that provides coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems denies any particular insured, participant, or beneficiary coverage for services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems, the plan shall, upon request, make the reason for the denial available to the insured, participant, or beneficiary, in addition to complying with s. 632.857, if applicable.

SECTION 34. 632.89 (5) (title) of the statutes is repealed and recreated to read:

632.89 **(5)** (title) EXCLUSIONS.

SECTION 35. 632.89 (5) of the statutes is renumbered 632.89 (5) (a).

SECTION 36. 632.89 (5) (a) (title) of the statutes is created to read:

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

SECTION 37. 632.89 (6) of the statutes is repealed.

SECTION 38. 632.89 (7) of the statutes is repealed.

SECTION 39. Initial applicability.

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

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

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

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

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

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

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

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

SECTION 40. Effective date.

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

(END)

INSERT 10-13

and for an individual health benefit plan that provides coverage of the treatment of nervous and mental disorders or alcoholism and other drug abuse problems,

(END OF INSERT 10-13)

INSERT 10-15

limitations regarding referrals to nonphysicians and treatment programs, as described in sub. (1) (e) 1., 3., and 4.;

(END OF INSERT 10-15)

INSERT 10-20

, annual or lifetime limit, or out-of-pocket limit

(END OF INSERT 10-20)

INSERT 11-4

, and an individual health benefit plan that provides coverage of the treatment of nervous and mental disorders or alcoholism and other drug abuse problems,

(END OF INSERT 11-4)

INSERT 11-11

or if an individual health benefit plan that provides coverage of the treatment of nervous and mental disorders or alcoholism and other drug abuse problems denies any particular insured coverage for services for that treatment,

(END OF INSERT 11-11)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3406/1dn
PJK:...

date

This draft makes a number of minor modifications to the language throughout s. 632.89, as well as the changes discussed during the conference call on September 23.

The language added to the list in proposed s. 632.89 (3) cross-references the nonphysician providers and programs under s. 632.89 (1) (e) 1., 3., and 4. It might be better to keep that language generic by taking out the cross-reference. Since the items on the list are intended to relate to both types of coverage (i.e., for mental health and drug abuse treatment and for treatment of physical conditions), the cross-reference could create a loophole. Since referrals to the providers and programs under s. 632.89 (1) (e) 1., 3., and 4. are probably not made for treatment of physical conditions, if a plan limited or even prohibited referrals to them for mental health and drug abuse treatment, that would not be more restrictive than limiting or prohibiting referrals to them for treatment of physical conditions.

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