State of Wisconsin
2009 − 2010 LEGISLATURE

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ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO 2009 ASSEMBLY BILL 512

January 28, 2010 − Offered by Representative PASCH.

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), 632.89 (4) 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), 632.89 (4) (title) and 632.89 (5) (title); and ***to create*** 111.91 (2) (qm), 609.71, 632.89 (1) (at), 632.89 (3), 632.89 (3c), 632.89 (3f), 632.89 (3p), 632.89 (4) (b), 632.89 (5) (a) (title) and 632.89 (5) (c) of the statutes; **relating to:** health insurance coverage of nervous and mental

disorders, alcoholism, and other drug abuse problems; providing an exemption from emergency rule procedures; and granting rule−making authority.

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 (mental health) and alcoholism and other drug abuse problems (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 substitute amendment 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 substitute amendment 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.

The substitute amendment requires that deductibles, copayments, out−of−pocket limits, limitations regarding referrals to nonphysicians, 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 or substance abuse problems, may not be more restrictive with respect to that coverage than the most common or frequent type of treatment limitations that apply to substantially all other coverage under the plan. The substitute amendment also requires that expenses incurred for the

treatment of mental health and substance abuse problems be included in any overall deductible amount, annual or lifetime limit, or out−of−pocket limit under the plan. The substitute amendment provides two exceptions to these equal coverage requirements. If, as a result of the new requirements, the total cost of coverage to an employer under a group health benefit plan or a governmental self−insured health plan for the treatment of mental health and substance abuse problems increases by more than 2 percent in the first plan year that the requirements apply, or by 1 percent in any plan year thereafter, the employer may elect for the employer's plan to be exempt during the following plan year from the new requirements and subject to the requirements for coverage of the treatment of mental health and substance abuse problems under current law. The cost increase must be determined by a qualified actuary. The second exception is for employers with fewer than ten employees. Any such employer may elect for the employer's plan to be exempt during a plan year from the new requirements and subject to the requirements under current law.

Finally, the substitute amendment 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 or 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 of that treatment; and 2) the reason for any denial of coverage for services for that treatment. 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.

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 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) (at) of the statutes is created to read:

632.89 **(1)** (at) "Group health benefit plan" has the meaning given in s. 632.745 (9).

SECTION 17. 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 18. 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 19. 632.89 (2) (title) of the statutes is amended to read:

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

SECTION 20. 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. (3) to (3f).

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

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

SECTION 23. 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 24. 632.89 (2) (c) 2. of the statutes is repealed.

SECTION 25. 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 26. 632.89 (2) (d) 2. of the statutes is repealed.

SECTION 27. 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 28. 632.89 (2) (dm) 2. of the statutes is repealed.

SECTION 29. 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 30. 632.89 (2m) of the statutes is renumbered 632.89 (4m).

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 that provide coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems, 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, 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; limitations regarding referrals to nonphysician providers and treatment programs; 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 or alcoholism and other drug abuse problems than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan. The plan shall include in any overall deductible amount or annual or lifetime limit or out−of−pocket limit for the plan, expenses incurred for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems.

SECTION 32. 632.89 (3c) of the statutes is created to read:

632.89 **(3c)** EXEMPTION FOR COST INCREASE. (a) Notwithstanding sub. (3), an employer that provides health care coverage for its employees through a group health benefit plan or a self−insured health plan that provides coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems may elect for the employer's plan to be exempt from the requirements

under sub. (3) during the plan year following any plan year in which, as a result of the requirements under sub. (3), there is an increase under the plan in the employer's total cost of coverage for the treatment of physical conditions and nervous and mental disorders and alcoholism and other drug abuse problems by a percentage that exceeds either of the following:

1. Two percent in the first plan year in which the requirements apply.

2. One percent in any plan year after the first plan year in which the requirements apply.

(b) A cost increase specified under par. (a) may not be determined until the employer's group health benefit plan or self−insured health plan has complied with the requirements under sub. (3) for at least the first 6 months of the plan year for which the increase is to be determined. The cost increase shall be determined, and certified, by a qualified actuary, as defined in s. 623.06 (1c). A copy of the actuary's determination, and all underlying documentation that the actuary relied on in making the determination, shall be filed with and, in accordance with rules promulgated by the commissioner, retained by the insurer issuing the group health benefit plan or by the self−insured health plan.

(c) A group health benefit plan or a self−insured health plan that qualifies for an exemption under par. (a) and for which the employer providing coverage under the plan has elected for the plan to be exempt from the requirements under sub. (3) during a plan year shall promptly notify all enrollees under the plan.

(d) Regardless of a cost increase as specified in par. (a), an employer may elect for the employer's plan to continue to be subject to the requirements under sub. (3). If an employer elects for the employer's plan to be exempt from the requirements under sub. (3), during the plan year in which it is exempt the group health benefit

plan or self−insured health plan shall comply with the coverage requirements under s. 632.89 (2) (a) to (dm), 2007 stats.

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

632.89 **(3f)** EXEMPTION FOR SMALL EMPLOYERS. (a) Notwithstanding sub. (3), an employer that provides health care coverage for its employees through a group health benefit plan that provides coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems may elect for the employer's plan to be exempt from the requirements under sub. (3) during a plan year if, on the first day of the plan year, the employer will have fewer than 10 eligible employees, as defined in s. 632.745 (5).

(b) A group health benefit plan that qualifies for an exemption under par. (a) and for which the employer providing coverage under the plan has elected for the plan to be exempt from the requirements under sub. (3) during a plan year shall promptly notify all enrollees under the employer's plan. During the plan year in which it is exempt from the requirements under sub. (3), the group health benefit plan shall comply with the coverage requirements under s. 632.89 (2) (a) to (dm), 2007 stats.

SECTION 34. 632.89 (3m) of the statutes is repealed.

SECTION 35. 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 that provide coverage of the treatment of nervous and mental disorders and alcoholism and other drug abuse problems, and an individual health benefit plan that provides coverage of the treatment of nervous and mental disorders or 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 or a 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 that treatment, 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, 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 36. 632.89 (4) (title) of the statutes is repealed and recreated to read:

632.89 **(4)** (title) RULES.

SECTION 37. 632.89 (4) of the statutes is renumbered 632.89 (4) (a).

SECTION 38. 632.89 (4) (b) of the statutes is created to read:

632.89 **(4)** (b) 1. The commissioner shall promulgate rules for the administration of this section, including rules that specify the information that must be provided in the notices under subs. (3c) (c) and (3f) (b) and the manner in which the notices must be given, that specify who is responsible for the actuarial study and determination under sub. (3c) (b), and that specify retention requirements for the determination and underlying documentation. In promulgating the rules, the commissioner shall follow, as a minimum standard, any relevant federal regulations or guidelines that are in effect.

2. Using the procedure under s. 227.24, the commissioner may promulgate the rules under subd. 1. for the period before the effective date of any permanent rules promulgated under subd. 1., but not to exceed the period authorized under s. 227.24

(1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subdivision as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to make a finding of emergency for a rule promulgated under this subdivision.

SECTION 39. 632.89 (5) (title) of the statutes is repealed and recreated to read:

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

SECTION 40. 632.89 (5) of the statutes is renumbered 632.89 (5) (a).

SECTION 41. 632.89 (5) (a) (title) of the statutes is created to read:

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

SECTION 42. 632.89 (5) (c) of the statutes is created to read:

632.89 **(5)** (c) *Coverage of autism treatment.* This section does not apply to coverage of treatment for autism spectrum disorder, as defined in s. 632.895 (12m) (a) 1., to which s. 632.895 (12m) applies.

SECTION 43. 632.89 (6) of the statutes is repealed.

SECTION 44. 632.89 (7) of the statutes is repealed.

SECTION 45. 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 governmental self−insured 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) Governmental self−insured 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 46. Effective date.

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

(END)