2009 DRAFTING REQUEST

Assembly Substitute Amendment (ASA-AB512)

Received: **01/12/2010**

Received By: **pkahler**

Wanted: **Soon**

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:

Pre Topic:

No specific pre topic given

Topic:

Mental health coverage parity

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 01/13/2010	jdyer 01/13/2010		_____ _____			
/1			rschluet 01/13/2010	_____ _____	sbasford 01/13/2010	sbasford 01/13/2010	
/2	pkahler 01/19/2010	jdyer 01/19/2010	jfrantze 01/20/2010	_____ _____	sbasford 01/20/2010	sbasford 01/20/2010	
/3	pkahler	jdyer	rschluet	_____	cduerst	cduerst	

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	01/27/2010	01/28/2010	01/28/2010	_____	01/28/2010	01/28/2010	

FE Sent For:

<END>

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/1		1/28 jd	rschluet 01/13/2010	_____ _____	sbasford 01/13/2010	sbasford 01/13/2010	
/2	pkahler 01/19/2010	jdyer 01/19/2010	jfrantze 01/20/2010	_____ _____	sbasford 01/20/2010	sbasford 01/20/2010	

1/28

FE Sent For:

<END>

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May Contact:

Addl. Drafters:

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/?	pkahler 01/13/2010	jdyer 01/13/2010					
/1		1/19 jld	rschluet 01/13/2010	1/19 PH	sbasford 01/13/2010	sbasford 01/13/2010	

FE Sent For:

<END> 1/20

2009 DRAFTING REQUEST

Assembly Substitute Amendment (ASA-AB512)

Received: **01/12/2010**

Received By: **pkahler**

Wanted: **Soon**

Identical to LRB:

For: Sandy Pasch **Donna Seidel (608) 266-0654**

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.Seidel@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Mental health coverage parity

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler	1/13 jld	1/13	1/13			

FE Sent For:

<END>

Kahler, Pam

From: Ludwig, Frederic
Sent: Wednesday, January 13, 2010 10:58 AM
To: Kahler, Pam
Subject: RE: re: parity predicament

Makes sense, so go for it!

From: Kahler, Pam
Sent: Wednesday, January 13, 2010 10:21 AM
To: Ludwig, Frederic
Subject: RE: re: parity predicament

Fred - one other thing. I had wished that I had provided a definition for "group health benefit plan" in the mental health section. I provided a definition for "health benefit plan," but the definition for "group health benefit plan" under s. 632.745 (9) brings in the concept that it is an employer-provided plan and also applies to individual plans if three or more are sold to or through the employer. Since I am doing a sub., this would be the perfect time to add it, if that's okay with you. Run it by Dick, if you have any qualms. Thanks!

Pam

From: Ludwig, Frederic
Sent: Tuesday, January 12, 2010 3:38 PM
To: Kahler, Pam
Subject: RE: re: parity predicament

You bet! Thanks Pam.

From: Kahler, Pam
Sent: Tuesday, January 12, 2010 3:38 PM
To: Ludwig, Frederic
Subject: RE: re: parity predicament

What I've done is sort of a hybrid. I'm requiring OCI to follow, as a minimum standard, any federal regulations or guidelines that are in effect. Sound ok?

From: Ludwig, Frederic
Sent: Tuesday, January 12, 2010 3:04 PM
To: Kahler, Pam
Subject: RE: re: parity predicament

Also, just wanted to make sure that you included your suggestion (require OCI to follow any federal regulations that are in effect/specify through rule any requirements necessary to ensure congruence between this law and the federal law

---

From: Kahler, Pam
Sent: Tuesday, January 12, 2010 1:26 PM
To: Ludwig, Frederic

Subject: RE: re: parity predicament

OK, so we are going to do a sub that incorporates the concept that Dick Sweet suggested (OCI doing rules, including emergency rules, for who is responsible for the actuarial study), using OCI's requested "minimum standard" language. Correct?

Pam

From: Ludwig, Frederic
Sent: Tuesday, January 12, 2010 12:30 PM
To: Kahler, Pam
Subject: RE: re: parity predicament

Hi Pam,

OCI requested that we include language that provides they must follow the federal guidelines "as the minimum standard" so they're not statutorily nailed down to federal regs if they want to go above what the feds require. Not sure how this would be defined, but let me know if you need further clarification. Also, to answer your question from Thursday, I think we'd like to go with a sub if that's convenient for you.

Fred

From: Kahler, Pam
Sent: Thursday, January 07, 2010 1:00 PM
To: Ludwig, Frederic
Subject: RE: re: parity predicament

Either a sub or one simple amendment that includes everything would be the easiest to understand. Just depends on what you want.

From: Ludwig, Frederic
Sent: Thursday, January 07, 2010 12:39 PM
To: Kahler, Pam
Subject: RE: re: parity predicament

Just had to laugh reading your first sentence in wondering how we got to this point...

Any of the options preferable/make most sense from your end of things? I'll pass it around for thought as well.

From: Kahler, Pam
Sent: Thursday, January 07, 2010 12:37 PM
To: Ludwig, Frederic
Subject: RE: re: parity predicament

Fred:

We cannot draft amendments to amendments to amendments. Since the language that the employer must pay is in the amendment (LRBa1230) to the amendment (LRBa1218) and we cannot draft an amendment to LRBa1230, the options are these:
1) Draft a sub with all the changes, including the new rules.
2) Draft a new simple amendment with all the changes, including the new rules.
3) Redraft LRBa1218 to do the same thing as number 2 above.
4) Draft a new amendment to LRBa1218 that removes the part about the employer paying and adds the new rules (or that notwithstands that language and adds the new rules).

5) Redraft LRBa1213 to do the same thing as number 4 above.

Pam

From: Ludwig, Frederic
Sent: Thursday, January 07, 2010 12:03 PM
To: Kahler, Pam
Subject: RE: re: parity predicament

1218/1 and 1230/2

From: Kahler, Pam
Sent: Thursday, January 07, 2010 12:02 PM
To: Ludwig, Frederic
Subject: RE: re: parity predicament

Can you give me the LRB number of the amendment? That way I can look at the language to see what needs to be changed.

From: Ludwig, Frederic
Sent: Thursday, January 07, 2010 11:15 AM
To: Kahler, Pam
Subject: RE: re: parity predicament

Thanks for the response, Pam. I was in the process of having a lengthy conversation with Deb Kraft when I got this, and we were having a hard time nailing down what part of the amendment (or the amendment to the amendment) would have to be changed in order to remain consistent with federal law (i.e. your suggestion below). If you and/or Dick think you'll be able to make the puzzle pieces fit, then great. However, we thought it might not be a bad idea to have a quick conversation as to how to best move forward with the intent of our changes.

Thoughts?

From: Kahler, Pam
Sent: Thursday, January 07, 2010 10:54 AM
To: Ludwig, Frederic
Subject: RE: re: parity predicament

Fred:

Dick's suggestion works for me. However, I would suggest that the agency be required to follow any federal regulations that are in effect. I assume that way they wouldn't have to wait for the federal regulations, but if the federal regulations differed from the rule when they went into effect, the rule would have to be amended.

Pam

From: Ludwig, Frederic
Sent: Wednesday, January 06, 2010 3:40 PM
To: Kahler, Pam
Subject: re: parity predicament

Hi Pam,

Back to bug you again after letting you relax over the holiday! Wanted to pass something by you and see what you think.

There were significant issues surrounding the actuarial determination requirement within the "cost exception requirement" of our parity amendment at the executive session. Our goal through this provision was to extend the federal exemption requirements through Wellstone-Domenici to most small group health plans. However, in our attempt to do so, it seems as if we have unintentionally triggered a battle in respect to who is responsible for the actuarial certification—and consequently paying for the study—under the federal language (health plan vs. employer).

That being said, we would like to maintain congruence between our bill and the federal requirements in respect to this issue but are looking for a way to do so that isn't contingent upon waiting for the federal regulations to come down. Therefore, we wanted to explore if there was a way to statutorily define that we will follow the federal regulation's lead on who is responsible for the actuarial estimate.

I ran this by Dick, and he provided the following suggestions:

- Require a state agency (OCI or DHS) to specify by rule who is responsible for the actuarial study
- Require that agency to give strong consideration to using the entity identified in federal regulations for this purpose
- Give the agency the authority to promulgate such a rule using the emergency rule-making process, without requiring that they make a finding of emergency

Let me know what you think when you get a chance or if you need some more info.

Fred

--

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

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-~~3406~~/2
PJK:jld:jf

TODAY by 4 p.m.
ASSEMBLY SUBSTITUTE AMENDMENT

s0237/1 → stays

SOON (in T-13)

To **2009 ASSEMBLY BILL 512**

*LPS - Fix requester on request sheet please

LPS check auto fixers

October 21, 2009 - Introduced by Representatives PASCH, RICHARDS, BENEDICT, SOLETSKI, SMITH, BLACK, PARISI, MILROY, KAUFERT, FIELDS, POPE-ROBERTS, ZEPNICK, HIXSON, ROYS, POCAN, A. OTT, BERCEAU, SINICKI, MOLEPSKE JR., GRIGSBY, YOUNG, TURNER, HEBL, SHERMAN, JORGENSEN, TOLES and HILGENBERG, cosponsored by Senators HANSEN, WIRCH, TAYLOR, ROBSON, LEHMAN, VINEHOUT, CARPENTER, LASSA, MILLER, RISSER, ERPENBACH and COGGS. Referred to Committee on Health and Healthcare Reform.

regenerate ↓

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.

granting rule-making authority; exemption from emergency rule procedures; providing an effective date

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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 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, 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 bill 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. In addition, the bill requires a group health

Substitute amendment

Substitute amendment

Insert A

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.

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) to (3f).

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 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 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:

Insert 10-22

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 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:

Insert 11-21 ✓

(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)

SECTION #. Insert 10-22 1082

632.89 **(3c)** EXEMPTION FOR COST INCREASE. (a) Notwithstanding sub. (3), 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) 1. 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 the commissioner and shall be available for public inspection.

Insert 10-22 A

(c) An employer A group health benefit plan or a self-insured health plan that qualifies for an exemption under par. (a) and elects for the employer's plan to be exempt from the requirements under sub. (3) during a plan year shall promptly notify the commissioner and all enrollees under the plan. The commissioner shall promulgate rules specifying the information that must be provided in the notice and the manner in which the notice must be given.

An employer that provides health care coverage for its employees through

ins 10-22 cont'd 2082

(d) Regardless of a cost increase as specified in par. (a), a group health benefit plan or self-insured health plan may elect to continue to be subject to the requirements under sub. (3). If a group health benefit plan or a self-insured health plan elects 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 31r. 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 may elect 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) An employer that qualifies for the exemption under par. (a) and elects to be exempt from the requirements under sub. (3) during a plan year shall promptly notify the commissioner and all enrollees under the employer's group health benefit plan. During the plan year in which the employer 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.

(c) The commissioner shall promulgate rules specifying the information that must be provided in the notice under par. (b) and the manner in which the notice must be given.".

8. Page 11, line 21: after that line insert:

"**SECTION 36m.** 632.89 (5) (c) of the statutes is created to read:

(end of insert 10-22)

insert 11-21
SECTION #. CR; 632.89(5)(c)

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.".

(END) (ins 11-21)

INSERT A

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 self-insured governmental plan for the treatment of mental health and substance abuse problems increases by more than two percent in the first plan year that the requirements apply, or by one 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 to be exempt during a plan year from the new requirements and subject to the requirements under current law.

Finally, the substitute amendment

(END OF INSERT A)

INSERT 7-18

SECTION 1. 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).

(END OF INSERT 7-18)

INSERT 10-22A (to Insert 10-22)

2. a. The commissioner shall promulgate rules specifying who is responsible for obtaining and paying for the actuarial study and determination under subd. 1. In promulgating the rules, the commissioner shall follow, as a minimum standard, any federal regulations or guidelines that are in effect with respect to the requirement.

b. Using the procedure under s. 227.24, the commissioner may promulgate the rules under subd. 2. a. for the period before the effective date of any permanent rules promulgated under subd. 2. a., 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

Ins 10-22A cont'd (to Ins 10-22)

commissioner is not required to provide evidence that promulgating a rule under this subd. 2. b. 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 subd. 2. b.

(END OF INSERT 10-22A) (to Ins 10-22)

INSERT 10-22B (to Insert 10-22)

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

(END OF INSERT 10-22B) (to Ins 10-22)

s0237 1-19-10

Fred → (1) health care plan not employer

(Rep Pasch)

acts w/ respect to OCI

En both exemptions

(2) OCI do rules generally re.

including specifics in draft

keep "as a minimum standard" language