



State of Wisconsin
2009 - 2010 LEGISLATURE

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ASSEMBLY SUBSTITUTE AMENDMENT,
TO 2009 ASSEMBLY BILL 512

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possible

repeal

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1 AN ACT *to repeal* 632.89 (2) (a) 2., 632.89 (2) (b), 632.89 (2) (c) 2., 632.89 (2) (d)
2 2., 632.89 (2) (dm) 2., 632.89 (3m), 632.89 (6) and 632.89 (7); *to renumber*
3 632.89 (2m) and 632.89 (5); *to renumber and amend* 632.89 (2) (a) 1., 632.89
4 (2) (c) 1., 632.89 (2) (d) 1., 632.89 (2) (dm) 1. and 632.89 (2) (e); *to amend* 40.51
5 (8), 40.51 (8m), 46.10 (8) (d), 46.10 (14) (a), 49.345 (8) (d), 49.345 (14) (a), 66.0137
6 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 301.12 (8) (d), 301.12 (14)
7 (a), 632.89 (title) and 632.89 (2) (title); *to repeal and recreate* 632.89 (1) (b),
8 632.89 (1) (em) and 632.89 (5) (title); and *to create* 111.91 (2) (qm), 609.71,
9 632.89 (1) (at), 632.89 (3), 632.89 (3c), 632.89 (3f), 632.89 (3p), 632.89 (5) (a)
10 (title) and 632.89 (5) (c) of the statutes; **relating to:** health insurance coverage
11 of nervous and mental disorders, alcoholism, and other drug abuse problems;

1 providing an exemption from emergency rule procedures; and granting
2 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 to be exempt during a plan year from the new requirements and subject to the requirements under current law.

for the employer's plan

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:

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

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

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

1 40.51 (8m) Every health care coverage plan offered by the group insurance
2 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
3 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, 632.89, and 632.895
4 (11) to (17).

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

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

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

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

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

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

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

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

10 49.345 (14) (a) Except as provided in pars. (b) and (c), liability of a person
11 specified in sub. (2) or s. 49.32 (1) for care and maintenance of persons under 18 years
12 of age in residential, nonmedical facilities such as group homes, foster homes,
13 treatment foster homes, subsidized guardianship homes, and residential care
14 centers for children and youth is determined in accordance with the cost-based fee
15 established under s. 49.32 (1). The department shall bill the liable person up to any
16 amount of liability not paid by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or by other
17 3rd-party benefits, subject to rules that include formulas governing ability to pay
18 established by the department under s. 49.32 (1). Any liability of the person not
19 payable by any other person terminates when the person reaches age 18, unless the
20 liable person has prevented payment by any act or omission.

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

23 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
24 a village provides health care benefits under its home rule power, or if a town
25 provides health care benefits, to its officers and employees on a self-insured basis,

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

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

5 111.91 (2) (qm) The requirements under s. 632.89 relating to coverage of
6 treatment for nervous and mental disorders and alcoholism and other drug
7 problems.

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

10 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
11 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
12 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895 (9) to (17),
13 632.896, and 767.513 (4).

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

16 185.981 (4t) A sickness care plan operated by a cooperative association is
17 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85,
18 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (10) to
19 (17), and 632.897 (10) and chs. 149 and 155.

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

22 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be
23 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
24 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
25 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853,

1 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (5) and (9) to (17),
2 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring
3 association shall:

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

5 301.12 (8) (d) After due regard to the case and to a spouse and minor children
6 who are lawfully dependent on the property for support, compromise or waive any
7 portion of any claim of the state or county for which a person specified under sub. (2)
8 is liable, but not any claim payable by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or
9 by any other 3rd party.

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

11 301.12 (14) (a) Except as provided in pars. (b) and (c), liability of a person
12 specified in sub. (2) or s. 301.03 (18) for care and maintenance of persons under 17
13 years of age in residential, nonmedical facilities such as group homes, foster homes,
14 treatment foster homes, residential care centers for children and youth and juvenile
15 correctional institutions is determined in accordance with the cost-based fee
16 established under s. 301.03 (18). The department shall bill the liable person up to
17 any amount of liability not paid by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or by
18 other 3rd-party benefits, subject to rules which include formulas governing ability
19 to pay promulgated by the department under s. 301.03 (18). Any liability of the
20 resident not payable by any other person terminates when the resident reaches age
21 17, unless the liable person has prevented payment by any act or omission.

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

23 **609.71 Coverage of alcoholism and other diseases.** Defined network
24 plans are subject to s. 632.89.

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

1 **632.89** (title) ~~Required coverage of~~ Coverage of mental disorders,
2 alcoholism, and other diseases.

3 **SECTION 16.** 632.89 (1) (at) of the statutes is created to read:

4 632.89 (1) (at) "Group health benefit plan" has the meaning given in s. 632.745
5 (9).

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

7 632.89 (1) (b) "Health benefit plan" has the meaning given in s. 632.745 (11).

8 **SECTION 18.** 632.89 (1) (em) of the statutes is repealed and recreated to read:.

9 632.89 (1) (em) "Self-insured health plan" has the meaning given in s. 632.745
10 (24).

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

12 632.89 (2) (title) REQUIRED COVERAGE FOR GROUP PLANS.

13 **SECTION 20.** 632.89 (2) (a) 1. of the statutes is renumbered 632.89 (2) (a) and
14 amended to read:

15 632.89 (2) (a) *Conditions covered.* A group ~~or blanket disability insurance~~
16 ~~policy issued by an insurer~~ health benefit plan and a self-insured health plan shall
17 provide coverage of nervous and mental disorders and alcoholism and other drug
18 abuse problems if required by pars. (c) to (dm) and as provided in pars. ~~(b)~~ (c) to (e)
19 (dm) and subs. (3) to (3f).

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

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

22 **SECTION 23.** 632.89 (2) (c) 1. of the statutes is renumbered 632.89 (2) (c) and
23 amended to read:

24 632.89 (2) (c) ~~Minimum coverage~~ Coverage of inpatient hospital services. If a
25 ~~group or blanket disability insurance policy issued by an insurer~~ health benefit plan

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

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

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

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

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

13 **SECTION 27.** 632.89 (2) (dm) 1. of the statutes is renumbered 632.89 (2) (dm)
14 and amended to read:

15 632.89 (2) (dm) ~~Minimum coverage~~ Coverage of transitional treatment
16 arrangements. If a group ~~or blanket disability insurance policy issued by an insurer~~
17 health benefit plan or a self-insured health plan provides coverage of any inpatient
18 hospital treatment or any outpatient treatment, the ~~policy plan~~ shall provide
19 coverage for transitional treatment arrangements for the treatment of conditions
20 under par. (a) ~~1. as provided in subd. 2.~~

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

22 **SECTION 29.** 632.89 (2) (e) of the statutes is renumbered 632.89 (5) (b) and
23 amended to read:

24 632.89 (5) (b) ~~Exclusion~~ Certain health care plans. This subsection ~~section~~ does
25 not apply to a health care plan offered by a limited service health organization, as

1 defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4),
2 that is not a defined network plan, as defined in s. 609.01 (1b).

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

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

5 632.89 (3) LIMITATIONS. For a group health benefit plan and a self-insured
6 health plan that provide coverage of the treatment of nervous and mental disorders
7 and alcoholism and other drug abuse problems, and for an individual health benefit
8 plan that provides coverage of the treatment of nervous and mental disorders or
9 alcoholism and other drug abuse problems, the exclusions and limitations;
10 deductibles; copayments; coinsurance; annual and lifetime payment limitations;
11 out-of-pocket limits; out-of-network charges; day, visit, or appointment limits;
12 limitations regarding referrals to nonphysician providers and treatment programs;
13 and duration or frequency of coverage limits under the plan may be no more
14 restrictive for coverage of the treatment of nervous and mental disorders or
15 alcoholism and other drug abuse problems than the most common or frequent type
16 of treatment limitations applied to substantially all other coverage under the plan.
17 The plan shall include in any overall deductible amount or annual or lifetime limit
18 or out-of-pocket limit for the plan, expenses incurred for the treatment of nervous
19 and mental disorders or alcoholism and other drug abuse problems.

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

21 632.89 (3c) EXEMPTION FOR COST INCREASE. (a) Notwithstanding sub. (3), an
22 employer that provides health care coverage for its employees through a group
23 health benefit plan or a self-insured health plan that provides coverage of the
24 treatment of nervous and mental disorders and alcoholism and other drug abuse
25 problems may elect for the employer's plan to be exempt from the requirements

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

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

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

9 (b) (1.) A cost increase specified under par. (a) may not be determined until the
10 employer's group health benefit plan[✓] or self-insured health plan[✓] has complied with
11 the requirements under sub. (3) for at least the first 6 months of the plan year for
12 which the increase is to be determined. The cost increase shall be determined, and
13 certified, by a qualified actuary, as defined in s. 623.06 (1c). A copy of the actuary's
14 determination, and all underlying documentation that the actuary relied on in
15 making the determination, shall be filed with the commissioner and shall be
16 available for public inspection. ✓

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

21 b. Using the procedure under s. 227.24, the commissioner may promulgate the
22 rules under subd. 2. a. for the period before the effective date of any permanent rules
23 promulgated under subd. 2. a., but not to exceed the period authorized under s.
24 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the
25 commissioner is not required to provide evidence that promulgating a rule under this

1 subd. 2. b. as an emergency rule is necessary for the preservation of the public peace,
2 health, safety, or welfare and is not required to make a finding of emergency for a rule
3 promulgated under this subd. 2. b.

4 (c) An employer that qualifies for an exemption under par. (a) and elects for the
5 employer's plan to be exempt from the requirements under sub. (3) during a plan
6 year shall promptly notify the commissioner and all enrollees under the plan. The
7 commissioner shall promulgate rules specifying the information that must be
8 provided in the notice and the manner in which the notice must be given.

9 (d) Regardless of a cost increase as specified in par. (a), an employer may elect
10 for the employer's plan to continue to be subject to the requirements under sub. (3).
11 If an employer elects for the employer's plan to be exempt from the requirements
12 under sub. (3), during the plan year in which the employer's plan is exempt it shall
13 comply with the coverage requirements under s. 632.89 (2) (a) to (dm), 2007 stats.

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

15 632.89 (3f) EXEMPTION FOR SMALL EMPLOYERS. (a) Notwithstanding sub. (3), an
16 employer that provides health care coverage for its employees through a group
17 health benefit plan that provides coverage of the treatment of nervous and mental
18 disorders and alcoholism and other drug abuse problems may elect for the employer's
19 plan to be exempt from the requirements under sub. (3) during a plan year if, on the
20 first day of the plan year, the employer will have fewer than 10 eligible employees,
21 as defined in s. 632.745 (5).

22 (b) An employer that qualifies for the exemption under par. (a) and elects for
23 the employer's plan to be exempt from the requirements under sub. (3) during a plan
24 year shall promptly notify the commissioner and all enrollees under the employer's
25 plan. During the plan year in which the employer's plan is exempt from the

Insert 12-4

Insert 12-22

the group health benefit plan or self-insured

group health benefit ✓

1 requirements under sub. (3), the employer's plan shall comply with the coverage
2 requirements under s. 632.89 (2) (a) to (dm), 2007 stats. ✓

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

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

7 SECTION 35. 632.89 (3p) of the statutes is created to read:

8 632.89 (3p) AVAILABILITY OF PLAN INFORMATION. A group health benefit plan and
9 a self-insured health plan that provide coverage of the treatment of nervous and
10 mental disorders and alcoholism and other drug abuse problems, and an individual
11 health benefit plan that provides coverage of the treatment of nervous and mental
12 disorders or alcoholism and other drug abuse problems, shall, upon request, make
13 available to any current or potential insured, participant, beneficiary, or contracting
14 provider the criteria for determining medical necessity under the plan with respect
15 to that coverage. If a group health benefit plan or a self-insured health plan that
16 provides coverage of the treatment of nervous and mental disorders and alcoholism
17 and other drug abuse problems denies any particular insured, participant, or
18 beneficiary coverage for services for that treatment, or if an individual health benefit
19 plan that provides coverage of the treatment of nervous and mental disorders or
20 alcoholism and other drug abuse problems denies any particular insured coverage
21 for services for that treatment, the plan shall, upon request, make the reason for the
22 denial available to the insured, participant, or beneficiary, in addition to complying
23 with s. 632.857, if applicable.

24 SECTION 36. 632.89 (5) (title) of the statutes is repealed and recreated to read:

25 632.89 (5) (title) EXCLUSIONS.

Insert 13-23 ✓

1 **SECTION 37.** 632.89 (5) of the statutes is renumbered 632.89 (5) (a).

2 **SECTION 38.** 632.89 (5) (a) (title) of the statutes is created to read:

3 632.89 (5) (a) (title) *Medicare.*

4 **SECTION 39.** 632.89 (5) (c) of the statutes is created to read:

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

8 **SECTION 40.** 632.89 (6) of the statutes is repealed.

9 **SECTION 41.** 632.89 (7) of the statutes is repealed.

10 **SECTION 42. Initial applicability.**

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

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

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

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

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

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

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

2009-2010 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

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PJK:.....

INSERT 12-4

1 ^{wdf} A group health benefit plan [✓] or a self-insured health plan [✓] that qualifies for an
2 exemption under par. (a) [✓] and for which the employer providing coverage under the
3 plan has elected ^{AS}

(END OF INSERT 12-4)

INSERT 12-22

4 ^{wdf} A group health benefit plan [✓] that qualifies for an exemption under [✓] par. (a) and
5 for which the employer providing coverage under the plan has elected ^{AS}

(END OF INSERT 12-22)

INSERT 13-23

6 SECTION 1. 632.89 (4) (title) [✓] of the statutes is repealed and recreated to read:
7 632.89 (4) (title) RULES. [✓]
8 SECTION 2. 632.89 (4) of the statutes is renumbered [✓] 632.89 (4) (a).
9 SECTION 3. 632.89 (4) (b) [✓] of the statutes is created to read:
10 632.89 (4) (b) 1. The commissioner [✓] shall promulgate rules for the
11 administration of this section [✓], including rules that specify the information that must
12 be provided in the notices under subs. (3c) (c) [✓] and (3f) (b) [✓] and the manner in which
13 the notices must be given and that specify who is responsible for the actuarial study
14 and determination under sub. [✓](3c) (b). In promulgating the rules, the commissioner
15 shall follow, as a minimum standard, any relevant federal regulations or guidelines
16 that are in effect.
17 2. Using the procedure under s. 227.24 [✓], the commissioner may promulgate the
18 rules under subd. 1. [✓] for the period before the effective date of any permanent rules



Ans 13-23 contd

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

(END OF INSERT 13-23)

STATE OF WISCONSIN - LEGISLATIVE REFERENCE BUREAU

LRB

Research (608-266-0341)

Library (608-266-7040)

Legal (608-266-3561)

LRB

for sub to SB 362 ^{ex} Tax & Keyfile 1-27

(1) file det + doc w/insurer & retain by
not available for public inspection
& retained in accordance w/
rules prescribed by the
Commissioners

(can keep language the same for rules)

also refer to OCI either

~~tax~~ based on SD 237/2
sub to AB 512



State of Wisconsin
2009 - 2010 LEGISLATURE

LRBs0237/3
PJK:jld:ff

rm is run

ASSEMBLY SUBSTITUTE AMENDMENT ,
TO 2009 ASSEMBLY BILL 512

SOON
(= 1-27)

LX

Regen

1 AN ACT *to repeal* 632.89 (2) (a) 2., 632.89 (2) (b), 632.89 (2) (c) 2., 632.89 (2) (d)
2 2., 632.89 (2) (dm) 2., 632.89 (3m), 632.89 (6) and 632.89 (7); *to renumber*
3 632.89 (2m), 632.89 (4) and 632.89 (5); *to renumber and amend* 632.89 (2) (a)
4 1., 632.89 (2) (c) 1., 632.89 (2) (d) 1., 632.89 (2) (dm) 1. and 632.89 (2) (e); *to*
5 *amend* 40.51 (8), 40.51 (8m), 46.10 (8) (d), 46.10 (14) (a), 49.345 (8) (d), 49.345
6 (14) (a), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 301.12 (8)
7 (d), 301.12 (14) (a), 632.89 (title) and 632.89 (2) (title); *to repeal and recreate*
8 632.89 (1) (b), 632.89 (1) (em), 632.89 (4) (title) and 632.89 (5) (title); and *to*
9 *create* 111.91 (2) (qm), 609.71, 632.89 (1) (at), 632.89 (3), 632.89 (3c), 632.89
10 (3f), 632.89 (3p), 632.89 (4) (b), 632.89 (5) (a) (title) and 632.89 (5) (c) of the
11 statutes; **relating to:** health insurance coverage of nervous and mental

1 disorders, alcoholism, and other drug abuse problems; providing an exemption
2 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:

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

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

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

1 40.51 (8m) Every health care coverage plan offered by the group insurance
2 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
3 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, 632.89, and 632.895
4 (11) to (17).

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

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

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

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

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

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

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

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

10 49.345 (14) (a) Except as provided in pars. (b) and (c), liability of a person
11 specified in sub. (2) or s. 49.32 (1) for care and maintenance of persons under 18 years
12 of age in residential, nonmedical facilities such as group homes, foster homes,
13 treatment foster homes, subsidized guardianship homes, and residential care
14 centers for children and youth is determined in accordance with the cost-based fee
15 established under s. 49.32 (1). The department shall bill the liable person up to any
16 amount of liability not paid by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or by other
17 3rd-party benefits, subject to rules that include formulas governing ability to pay
18 established by the department under s. 49.32 (1). Any liability of the person not
19 payable by any other person terminates when the person reaches age 18, unless the
20 liable person has prevented payment by any act or omission.

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

23 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
24 a village provides health care benefits under its home rule power, or if a town
25 provides health care benefits, to its officers and employees on a self-insured basis,

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

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

5 111.91 (2) (qm) The requirements under s. 632.89 relating to coverage of
6 treatment for nervous and mental disorders and alcoholism and other drug
7 problems.

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

10 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
11 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
12 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895 (9) to (17),
13 632.896, and 767.513 (4).

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

16 185.981 (4t) A sickness care plan operated by a cooperative association is
17 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85,
18 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (10) to
19 (17), and 632.897 (10) and chs. 149 and 155.

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

22 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be
23 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
24 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
25 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853,

1 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (5) and (9) to (17),
2 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring
3 association shall:

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

5 301.12 (8) (d) After due regard to the case and to a spouse and minor children
6 who are lawfully dependent on the property for support, compromise or waive any
7 portion of any claim of the state or county for which a person specified under sub. (2)
8 is liable, but not any claim payable by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or
9 by any other 3rd party.

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

11 301.12 (14) (a) Except as provided in pars. (b) and (c), liability of a person
12 specified in sub. (2) or s. 301.03 (18) for care and maintenance of persons under 17
13 years of age in residential, nonmedical facilities such as group homes, foster homes,
14 treatment foster homes, residential care centers for children and youth and juvenile
15 correctional institutions is determined in accordance with the cost-based fee
16 established under s. 301.03 (18). The department shall bill the liable person up to
17 any amount of liability not paid by an insurer under s. 632.89 (2) or ~~(2m)~~ (4m) or by
18 other 3rd-party benefits, subject to rules which include formulas governing ability
19 to pay promulgated by the department under s. 301.03 (18). Any liability of the
20 resident not payable by any other person terminates when the resident reaches age
21 17, unless the liable person has prevented payment by any act or omission.

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

23 **609.71 Coverage of alcoholism and other diseases.** Defined network
24 plans are subject to s. 632.89.

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

1 **632.89** (title) ~~Required coverage of~~ Coverage of mental disorders,
2 alcoholism, and other diseases.

3 **SECTION 16.** 632.89 (1) (at) of the statutes is created to read:

4 632.89 (1) (at) "Group health benefit plan" has the meaning given in s. 632.745
5 (9).

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

7 632.89 (1) (b) "Health benefit plan" has the meaning given in s. 632.745 (11).

8 **SECTION 18.** 632.89 (1) (em) of the statutes is repealed and recreated to read:

9 632.89 (1) (em) "Self-insured health plan" has the meaning given in s. 632.745
10 (24).

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

12 632.89 (2) (title) REQUIRED COVERAGE FOR GROUP PLANS.

13 **SECTION 20.** 632.89 (2) (a) 1. of the statutes is renumbered 632.89 (2) (a) and
14 amended to read:

15 632.89 (2) (a) *Conditions covered.* A group ~~or blanket disability insurance~~
16 ~~policy issued by an insurer~~ health benefit plan and a self-insured health plan shall
17 provide coverage of nervous and mental disorders and alcoholism and other drug
18 abuse problems if required by pars. (c) to (dm) and as provided in pars. ~~(b) (c) to (e)~~
19 (dm) and subs. (3) to (3f).

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

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

22 **SECTION 23.** 632.89 (2) (c) 1. of the statutes is renumbered 632.89 (2) (c) and
23 amended to read:

24 632.89 (2) (c) ~~Minimum coverage~~ Coverage of inpatient hospital services. If a
25 ~~group or blanket disability insurance policy issued by an insurer~~ health benefit plan

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

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

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

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

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

13 **SECTION 27.** 632.89 (2) (dm) 1. of the statutes is renumbered 632.89 (2) (dm)
14 and amended to read:

15 632.89 (2) (dm) ~~Minimum coverage~~ Coverage of transitional treatment
16 arrangements. If a group or ~~blanket disability insurance policy issued by an insurer~~
17 health benefit plan or a self-insured health plan provides coverage of any inpatient
18 hospital treatment or any outpatient treatment, the ~~policy plan~~ shall provide
19 coverage for transitional treatment arrangements for the treatment of conditions
20 under par. (a) ~~1. as provided in subd. 2.~~

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

22 **SECTION 29.** 632.89 (2) (e) of the statutes is renumbered 632.89 (5) (b) and
23 amended to read:

24 632.89 (5) (b) ~~Exclusion~~ Certain health care plans. This subsection ~~section~~ does
25 not apply to a health care plan offered by a limited service health organization, as

1 defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4),
2 that is not a defined network plan, as defined in s. 609.01 (1b).

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

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

5 632.89 (3) LIMITATIONS. For a group health benefit plan and a self-insured
6 health plan that provide coverage of the treatment of nervous and mental disorders
7 and alcoholism and other drug abuse problems, and for an individual health benefit
8 plan that provides coverage of the treatment of nervous and mental disorders or
9 alcoholism and other drug abuse problems, the exclusions and limitations;
10 deductibles; copayments; coinsurance; annual and lifetime payment limitations;
11 out-of-pocket limits; out-of-network charges; day, visit, or appointment limits;
12 limitations regarding referrals to nonphysician providers and treatment programs;
13 and duration or frequency of coverage limits under the plan may be no more
14 restrictive for coverage of the treatment of nervous and mental disorders or
15 alcoholism and other drug abuse problems than the most common or frequent type
16 of treatment limitations applied to substantially all other coverage under the plan.
17 The plan shall include in any overall deductible amount or annual or lifetime limit
18 or out-of-pocket limit for the plan, expenses incurred for the treatment of nervous
19 and mental disorders or alcoholism and other drug abuse problems.

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

21 632.89 (3c) EXEMPTION FOR COST INCREASE. (a) Notwithstanding sub. (3), an
22 employer that provides health care coverage for its employees through a group
23 health benefit plan or a self-insured health plan that provides coverage of the
24 treatment of nervous and mental disorders and alcoholism and other drug abuse
25 problems may elect for the employer's plan to be exempt from the requirements

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

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

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

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

16 available for public inspection.

Insert 11-16 ✓

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

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

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

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

4 632.89 (3f) EXEMPTION FOR SMALL EMPLOYERS. (a) Notwithstanding sub. (3), an
5 employer that provides health care coverage for its employees through a group
6 health benefit plan that provides coverage of the treatment of nervous and mental
7 disorders and alcoholism and other drug abuse problems may elect for the employer's
8 plan to be exempt from the requirements under sub. (3) during a plan year if, on the
9 first day of the plan year, the employer will have fewer than 10 eligible employees,
10 as defined in s. 632.745 (5).

11 (b) A group health benefit plan that qualifies for an exemption under par. (a)
12 and for which the employer providing coverage under the plan has elected for the
13 plan to be exempt from the requirements under sub. (3) during a plan year shall
14 promptly notify the commissioner and all enrollees under the employer's plan.
15 During the plan year in which it is exempt from the requirements under sub. (3), the
16 group health benefit plan shall comply with the coverage requirements under s.
17 632.89 (2) (a) to (dm), 2007 stats.

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

19 **SECTION 35.** 632.89 (3p) of the statutes is created to read:

20 632.89 (3p) AVAILABILITY OF PLAN INFORMATION. A group health benefit plan and
21 a self-insured health plan that provide coverage of the treatment of nervous and
22 mental disorders and alcoholism and other drug abuse problems, and an individual
23 health benefit plan that provides coverage of the treatment of nervous and mental
24 disorders or alcoholism and other drug abuse problems, shall, upon request, make
25 available to any current or potential insured, participant, beneficiary, or contracting

1 provider the criteria for determining medical necessity under the plan with respect
 2 to that coverage. If a group health benefit plan or a self-insured health plan that
 3 provides coverage of the treatment of nervous and mental disorders and alcoholism
 4 and other drug abuse problems denies any particular insured, participant, or
 5 beneficiary coverage for services for that treatment, or if an individual health benefit
 6 plan that provides coverage of the treatment of nervous and mental disorders or
 7 alcoholism and other drug abuse problems denies any particular insured coverage
 8 for services for that treatment, the plan shall, upon request, make the reason for the
 9 denial available to the insured, participant, or beneficiary, in addition to complying
 10 with s. 632.857, if applicable.

11 **SECTION 36.** 632.89 (4) (title) of the statutes is repealed and recreated to read:
 12 632.89 (4) (title) RULES.

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

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

15 632.89 (4) (b) 1. The commissioner shall promulgate rules for the
 16 administration of this section, including rules that specify the information that must
 17 be provided in the notices under subs. (3c) (c) and (3f) (b) and the manner in which
 18 the notices must be given ² and that specify who is responsible for the actuarial study
 19 and determination under sub. (3c) (b). ^{Insert 13-19 ✓} In promulgating the rules, the commissioner
 20 shall follow, as a minimum standard, any relevant federal regulations or guidelines
 21 that are in effect.

22 2. Using the procedure under s. 227.24, the commissioner may promulgate the
 23 rules under subd. 1. for the period before the effective date of any permanent rules
 24 promulgated under subd. 1., but not to exceed the period authorized under s. 227.24
 25 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner

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

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

6 632.89 (5) (title) **EXCLUSIONS.**

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

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

9 632.89 (5) (a) (title) *Medicare.*

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

11 632.89 (5) (c) *Coverage of autism treatment.* This section does not apply to
12 coverage of treatment for autism spectrum disorder, as defined in s. 632.895 (12m)
13 (a) 1., to which s. 632.895 (12m) applies.

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

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

16 **SECTION 45. Initial applicability.**

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

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

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

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

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1 ↗ and, in accordance with rules promulgated by the commissioner, ✓ retained by
2 the insurer issuing the group health benefit plan or by the self-insured health plan ✓

(END OF INSERT 11-16)

INSERT 13-19

3 ↗ , and that specify retention requirements for the determination and underlying
4 documentation ✓

(END OF INSERT 13-19)