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Details: Emergency Rules by Office of the Commissioner of Insurance.
(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10
(session year)

Joint
(Assembly, Senate or Joint)

Committee for Review of Administrative Rules ...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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November 22, 2010

THE HONORABLE JIM HOLPERIN
SENATE CO-CHAIRPERSON
JOINT COMM FOR REVIEW OF ADM RULES
SOUTH STATE CAPITOL RM 409
MADISON WI 53702

Re: Emergency Rule affecting section Ins 3.35, Wis. Adm. Code, relating to colorectal cancer screening coverage and affecting small business

Dear Senator Holperin:

I will be promulgating an emergency rule. Attached is a draft of the rule for your review. The reasons for proceeding with an emergency rule are given in the Finding of Emergency in the rule. It will be published in the official State newspaper in about a week.

If you have any questions, please contact Julie E. Walsh at (608) 264-8101 or e-mail at julie.walsh@wisconsin.gov.

Sincerely,

Sean Dilweg
Commissioner of Insurance

SD:JW
Attachment: 1 copy draft rule

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE CREATING A RULE

To create Ins 3.35, Wis. Adm. Code,

Relating to colorectal cancer screening coverage and affecting small business.

FINDING OF EMERGENCY

The Commissioner of Insurance finds that an emergency exists and that the attached rule is necessary for the immediate preservation of the public peace, health, safety, or welfare. Facts constituting the emergency are as follows:

Beginning December 1, insurers offering disability insurance policies and self-insured governmental plans are required to offer coverage for colorectal cancer screening. In order to ensure there is no gap in coverage the office needs to promulgate guidance as directed s. 632.895 (16m) (d), Stats., in advance of the initial implementation date.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 600.01, 628.34 (12), 632.895 (16m), Stats.

2. **Statutory authority:**

   ss. 600.01 (2), 601.41 (3), 601.42, 628.34 (12), 632.895 (16m), Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

   2009 Wis. Act 346 created s. 632.895 (16m), Stats., and required the commissioner to promulgate rules that specify guidelines for the colorectal cancer screening that must be covered, specify the factors for determining whether an individual is at high risk for colorectal cancer and to update periodically the guidelines as medically appropriate.

4. **Related statutes or rules:**

   None

5. **The plain language analysis and summary of the proposed rule:**

   The proposed rule implements s. 632.895 (16m), Stats., mandating coverage for colorectal cancer screening. For flexibility, the proposed rule allows insurers and

self-insured governmental plans to select from among the U.S. Preventive Services Task Force, the National Cancer Institute, or the American Cancer Society guidelines it will follow related to colorectal cancer screening intervals and specific screening tests or procedures. Insurers and self-insured governmental health plans are to inform enrollees of the guideline or guidelines they use and if they use more than one guideline, which guideline is primary if a dispute arises.

The proposed rule requires insurers and self-funded governmental plans to provide coverage of at least three of four identified screening tools: fecal occult blood test, flexible sigmoidoscopy, colonoscopy and computerized tomographic colonography. The determination for appropriate screening test or procedure is to be based upon medical necessity or medically appropriate basis and is eligible for internal and independent review.

Additionally, the proposed rule sets forth guidance on determination of persons at high risk for developing colorectal cancer. The proposed guidance is based upon the guidelines of the American Cancer Society as it is the only organization that has detailed standards for high risk categories and screening intervals. However, the rule does permit insurers to utilize additional criteria if the National Cancer Institute or the U.S. Preventive Service Task Force develops high risk criteria.

In light of federal health reform, the proposed rule requires insurers to comply with preventive services contained in the patient protection and affordable care act of 2010, PL 111-148, as amended by the federal health care and education reconciliation act of 2010, P.L. 111-152. Finally, insurers and self-insured governmental health plans are required to annually review the selected guidelines and comply with updates in the subsequent policy year.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

The patient protection and affordable care act of 2010, PL 111-148, as amended by the federal health care and education reconciliation act of 2010, P.L. 111-152, ("ACA"), includes colorectal cancer screening as a covered preventive health service contained in the 45 CFR Subtitle A §147.130. However, the federal requirements for preventive health are not effective until January 1, 2014. The federal regulation addresses cost sharing limitations that insurers may impose when the service is a preventive health service that supersede the state's law when implemented in 2014. The federal regulations and the ACA are not as specific as s. 632.895 (16m), Stats., and do not address high risk factors, therefore the state's law would not be preempted.

7. **Comparison of similar rules in adjacent states as found by OCI:**

Illinois: 215ILCS5/356x) Sec. 356x. Mandate provides coverage for colorectal cancer examination and screening in accordance with the published American Cancer Society guidelines. Illinois law also permits consideration of other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. The Illinois mandate restricts insurers from imposing deductible, coinsurance, waiting period, or other cost-sharing limitations that is greater than that required for other coverage under the policy.

Iowa: No similar law.

Michigan: No similar law.

Minnesota: Minnesota statutes section 62A.30 mandates coverage for accident and health insurance, health maintenance organizations excluding fixed indemnity and accident only policies. Every policy or plan must provide coverage of routine screening procedures for cancer and the office or facility visit. Among the cancer screenings listed colorectal cancer is included. Reference is made to include other

proven ovarian cancer screening evaluated by the federal food and drug administration or the National Cancer Institute.

8. **A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

OCI surveyed insurers doing business in Wisconsin regarding coverage of screening tests and procedures for colorectal cancer and found that of the insurers surveyed, all insurers currently provide coverage for some form of colorectal cancer screening.

As to guidelines, OCI consulted with the department of health services, representatives and discussed the proposed rule with interested parties including the American Cancer Society, Wisconsin Radiological Society, Wisconsin Association of Health Plans and numerous providers. The guidelines utilized in the rule include not only the American Cancer Society but also National Cancer Institute and the U. S. Preventive Services Task Force.

9. **Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:**

There are no insurers that offer comprehensive health insurance that qualify as small businesses in accordance with s. 227.114 (1), Wis. Stat. Intermediaries that solicit individual health insurance will be required to use the new form but since it is available at no cost from the office, the effect will be minimal.

10. **See the attached Private Sector Fiscal Analysis.**

There will be no significant fiscal effect on the private sector as the proposed rules add a benefit for consumers with little additional cost since most if not all insurers and self-funded governmental plans currently provide coverage.

11. **A description of the Effect on Small Business:**

This rule will require intermediaries to learn about the colorectal cancer benefit but will not have a fiscal impact.

12. **Agency contact person:**

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 335
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 335
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53703-3474

Email address:

Julie E. Walsh
julie.walsh@wisconsin.gov

Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins 3.35 (title) is created to read:

Ins 3.35 (title) **Colorectal cancer screening coverage**.

Ins 3.35 **(1)** APPLICABILITY. (a) This section applies to disability insurance policies as defined at s. 632.895 (1) (a), Stats., unless otherwise excepted in s. 632.895 (16m) (c), Stats., including Medicare supplement and cost plans that are issued or renewed on or after December 1, 2010. This section applies to Medicare supplement and cost plans but does not include limited –scope plans including vision and dental, hospital indemnity, income continuation, accident-only benefits, and long-term care policies. This section also applies to self-insured health plans as defined at s. 632.745 (24), Stats.

(b) For a disability insurance policy and a self-insured governmental health plan covering employees who are affected by a collective bargaining agreement the coverage under this section first applies as follows:

1. If the collective bargaining agreement contains provisions consistent with s. 632.895 (16m), Stats., coverage under this section first applies the earliest of any of the following: the date the disability insurance policy is issued or renewed on or after December 1, 2010, or the date the self-insured governmental health plan is established, modified, extended or renewed on or after December 1, 2010.

2. If the collective bargaining agreement contains provisions inconsistent with s. 632.895 (16m), Stats., the coverage under this section first applies on the date the health benefit plan is first issued or renewed or a self-insured governmental health plan is first established, modified, extended, or renewed on or after the earlier of the date the collectively bargained agreement expires, or the date the collectively bargained agreement is modified, extended or renewed.

(2) DEFINITIONS. In addition to the definitions contained in s. 632.895 (1), Stats., for purposes of this section all the following apply:

(a) "Designated guideline" means the recommendations of the U.S. Preventive Services Task Force, the National Cancer Institute, or the American Cancer Society regarding colorectal cancer screening guidelines identified by the insurer or self-insured governmental health plan for compliance.

(b) "Self-insured governmental health plan" means a self-insured governmental health plan offered by the state, county, city, village, town, or school district that provides coverage of any diagnostic or surgical procedure.

(3) COLORECTAL CANCER SCREENING GUIDELINES. Insurers may utilize one or more of the most current colorectal cancer screening guidelines issued by the U.S. Preventive Services Task Force, the National Cancer Institute, or the American Cancer Society as the basis for the coverage offered for preventive colorectal cancer screening tests and procedures.

If an insurer or self-insured governmental health plan elects to designate more than one guideline, the insurer or self-insured governmental health plan shall specify the guideline that will be primary in the event of a conflict between the designated guidelines. Insurers shall provide notice of the selected guideline or guidelines and which guideline is primary in a prominent location within the plan summary and in the notice provided to insureds when a benefit is denied based upon the primary guideline.

(4) COVERED SCREENING. Insurers offering disability insurance and self-insured health plans must offer as a covered benefit the screening for colorectal cancer subject to limitations, exclusions and cost-sharing provisions that generally apply under the plan and comply with all of the following:

(a) Insurers and self-insured health plans must cover evidence-based, recommended preventive colorectal cancer screening tests or procedures contained in the most current version of the designated guideline.

(b) In accordance with the most current recommendations from the designated guideline for frequency of testing, insurers and self-insured health plans shall provide as a covered benefit, colorectal cancer screening tests or procedures for enrollees who are 50 years of age or older except as provided for in sub. (5) (b). Covered screening tests or procedures shall at least include 3 of the following as determined to be medically appropriate or medically necessary:

1. Fecal occult blood test.

2. Flexible sigmoidoscopy.

3. Colonoscopy.

4. Computerized tomographic colonography.

(c) Insurers and self-insured health plans may require the enrollee's health care provider or the enrollee's primary care provider to obtain prior authorization for screening tests or procedures when the screening test or procedure is not contained in the most current version of guideline recommendations designated by the insurer or self-insured health plan

(d) Disputes regarding coverage of medically appropriate or medically necessary evidence-based screening tests or procedures are subject to internal grievance and independent review.

(5) FACTORS FOR HIGH RISK. (a) In accordance with recommended factors for identifying persons at high risk for colorectal cancer developed by the American Cancer Society, insurers and self-insured health plans must provide as a covered benefit evidence-based colorectal cancer screening tests and procedures at recommended ages and intervals for enrollees determined to be at high risk for developing colorectal cancer. Insurers and self-insured health plans that designated either the U.S. Preventive Services Task Force or the National Cancer Institute as the designated guideline may include additional high risk factors when the guidelines identify factors for persons at high risk for colorectal cancer. All insurers and self-insured health plans shall at a minimum consider all of the following factors, as appropriate, when determining whether an enrollee is at high risk for colorectal cancer:

1. Personal history of colorectal cancer, polyps or chronic inflammatory bowel disease.

2. Strong family history in a first-degree relative or two or more second-degree relatives of colorectal cancer or polyps.

3. Personal history or family history in a first or second-degree relative of hereditary colorectal cancer syndromes.

4. Other conditions, symptoms or diseases that are recognized as elevating one's risk for colorectal cancer as determined by the U.S. Preventive Services Task Force, the National Cancer Institute or the American Cancer Society.

(b) Notwithstanding sub. (4) (b), insurers and self-insured governmental health plans must provide as a covered benefit evidence-based, recommended colorectal cancer screening tests or procedures for high risk enrollees no later than the earliest recommended age determined to be medically appropriate or medically necessary.

(c) Disputes regarding an enrollee's status as being at high risk or factors to be considered as high risk for colon cancer are subject to internal grievance and independent review.

(6) PREVENTIVE SERVICES COMPLIANCE. Notwithstanding s. 632.895 (16m), Stats., insurers and self-insured governmental health plans must comply with P.L. 111-148 and 45 CFR Part 147 relating to cost-sharing provisions of preventive services including colon cancer screening.

(7) UPDATED GUIDELINES. Insurers and self-insured governmental health plans are required to comply with the most current colorectal cancer screening recommendations designated by the insurer and self-insured governmental health plan except as provided in sub. (4) (b) and (5). Insurers and self-insured governmental health plans shall at least annually review recommendations of the designated guideline and reflect the recommendations of most current version of the designated guideline as covered benefits for the subsequent policy year.

SECTION 2. This section may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 3. These changes apply to policies issued or renewed on or after December 1, 2010.

SECTION 4. This emergency rule will take effect on November 29, 2010, as provided in s. 227.24(1) (c), Stats.

Dated at Madison, Wisconsin, this 22 day of November, 2010.

Sean Dilweg
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

For s. Ins 3.35 relating to colorectal cancer screening coverage and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.

Division of Executive Budget and Finance
DOA-2047 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 335**

Subject
colorectal cancer coverage and affecting small business

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	Annualized Fiscal impact on State funds from: Increased Costs	Decreased Costs
A. State Costs by Category		
State Operations - Salaries and Fringes	$ 0	$ -0
(FTE Position Changes)	(0 FTE)	(-0 FTE)
State Operations - Other Costs	0	-0
Local Assistance	0	-0
Aids to Individuals or Organizations	0	-0
TOTAL State Costs by Category	$ 0	$ -0
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	$ 0	$ -0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	$ 0	$ -0
GPR Earned	0	-0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
TOTAL State Revenues	$ 0 None	$ -0 None

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ None 0	$ None 0
NET CHANGE IN REVENUES	$ None 0	$ None 0

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)
		11/22/2010

Division of Executive Budget and Finance
DOA-2048 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 335**

Subject
colorectal cancer coverage and affecting small business

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others ____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected
☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)
		11/22/2010


FORWARD
E PLURIBUS UNUM

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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November 22, 2010

THE HONORABLE JIM HOLPERIN
SENATE CO-CHAIRPERSON
JOINT COMM FOR REVIEW OF ADM RULES
SOUTH STATE CAPITOL RM 409
MADISON WI 53702

Re: Emergency Rule affecting Section Ins 3.37 and 3.375, Wis. Adm. Code, relating to nervous and mental disorders and substance use disorders and affecting small business

Dear Senator Holperin:

I will be promulgating an emergency rule. Attached is a draft of the rule for your review. The reasons for proceeding with an emergency rule are given in the Finding of Emergency in the rule. It will be published in the official State newspaper in about a week.

If you have any questions, please contact Julie E. Walsh at (608) 264-8101 or e-mail at julie.walsh@wisconsin.gov.

Sincerely,

Sean Dilweg
Commissioner of Insurance

SD:JW
Attachment: 1 copy draft rule

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE AMENDING AND CREATING A RULE

To amend s. Ins 3.37 (1) to (5) (intro);

To create s. Ins. 3.37 (2m), (3m), (4m) and (5m), and 3.375, Wis. Adm. Code;

Relating to health insurance coverage of nervous and mental disorders and substance use disorders, and affecting small business

---

EXEMPTION FROM FINDING OF EMERGENCY

The legislature by s. 632.89 (4) (b) 2., Stats., provides an exemption from a finding of emergency for adoption of the rule. Section 632.89 (4) (b) 2., Stats., reads as follows:

> s. 632.89 (4) (b) 2. Using the procedure under s. 227.24, the commissioner may promulgate the rules under subd. 1., for the period before the effective date of any permanent rules promulgated under subd.1., but not to exceed the period authorized under 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subdivision as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to make a finding of emergency for a rule promulgated under this subdivision.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   s. 600.01, 628.34 (12), and 632.89, Stats.

2. **Statutory authority:**

   ss. 600.01 (2), 601.41 (3), 601.42, 628.34 (12), and 632.89, Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

   The commissioner is required to promulgate rules to implement recreated s. 632.89, Stats., pursuant to s. 632.89 (4) (b), Stats., ensuring that insurers offering group health benefit plans and self-funded governmental plans include as a covered benefit the treatment of nervous and mental disorders and substance use disorders. In addition s.

632.89 (4) (a), Stats., requires the commissioner to promulgate rules relating to transitional treatment.

4. Related statutes or rules:

Section 609.71, Stats., was also created by 2009 Wis. Act 218 requiring defined health plans comply with the requirements contained in s. 632.89 and s. Ins 3.37, Wis. Admin. Code describe coverage for transitional treatment as required by s. 632.89 (4) (a), Stats.

5. The plain language analysis and summary of the proposed rule:

The proposed rule implements the recreated s. 632.89, Stats., instituting mental health parity in the treatment of nervous and mental disorders and substance use disorders. The proposed rule amends regulations relating to transitional treatment coverage and creates a new section for implementing requirements for the coverage of nervous and mental disorders and substance use disorders.

The transitional treatment regulation is bifurcated into requirements for plans issued on or after November 1, 2007 and prior to December 1, 2010 and parallel numbered sections for polices issued on or after December 1, 2010. For existing policies or policies for which an employer has requested an exemption pursuant to s. 632.89 (3c) or (3f), Stats., the requirements reflect s. 632.89, 2007 Stats., and updated cites and provisions of regulations contained in the department of health services pertaining to transitional treatment.

For plans issued on or after December 1, 2010, parallel requirements are created within the proposed revisions to s. Ins 3.37 to apply to insurers offering group health insurance plans and for self-insured governmental plans on a going forward basis. The types of services are the same except for removal of minimum dollar limitations and the types of insurers or self-insured governmental plans to which the requirements apply.

Concerns were raised regarding compliance with the PPACA requirement of no annual limits for essential benefits and s. 632.89 (2), 2007 Stat., benefit levels. The concerns were silenced after identifying that the s. 632.89 (2), 2007 Stat., are written as "not less than" so act as benefit floors and do not preclude exceeding the floor amount therefore not volatile of the federal law.

The proposed rule also creates s. Ins 3.375, Wis. Adm. Code, to implement s. 632.89, Stats., for policies issued on or after December 1, 2010, that requires insurers offering group health insurance and self-insured governmental plans to provide coverage for the treatment of nervous and mental disorders and substance use disorders no more restrictively than coverage for the most common or frequent type of treatment limitations that are applied to substantially all other coverage under the plan. This means insurers and self-insured governmental plans cannot impose limited benefits or impose different cost-sharing provisions based upon receiving nervous, mental or substance use disorders treatment. The rule defines "substantially all" to mean that the terms of coverage for nervous, mental and substance use disorders is to be treated no more restrictively than a single type of financial requirements or quantitative treatment limitations that apply to two-thirds of covered medical or surgical benefits.

Pursuant to s. 632.89 (3c), Stats., for employers seeking an exemption based upon increased costs related to the parity requirements, employers may request insurers to have a qualified actuary determine, at the insurer's cost, whether the employer is eligible for the exemption. Nothing in the rule, however, limits or prohibits an employer or self-funded governmental plan from obtaining, at their cost, a qualified actuarial determination.

Proposed s. Ins 3.375 (5), contains provisions governing insurers offering individual health benefit plans that contain benefits for the treatment of nervous and

mental disorders or substance use disorders. Insurers offering these individual health benefit plans shall make available the criteria for determining medical necessity and if the individual health benefit plan denies benefits related to nervous and mental disorders or substance use disorders it shall make the reason for the denial available to the insured, participant, or beneficiary in addition to complying with s. 632.857, Stats.

For eligible employers electing an exemption, Appendix 1 and 2 contain the model notices that insurers are to provide to employers or self-insured governmental plans that the employer is to post and distribute to employees explaining the basis of the exemption as well as a list of the benefits that will be provided to the employees as was contained in s. 632.89, 2007 Stats.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), was effective October 1, 2009 with interim final regulations published in February 2010. Wisconsin's 2009 Wis. Act 218 paralleled many provisions of the federal law in the statute and enhanced coverage benefits for Wisconsin consumers insured through small employers and covered by individual health benefit plans.

Additionally, the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, as amended by the Federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (jointly "PPACA"), identifies the treatment for mental health benefits and substance use disorders as an essential benefit that is to be contained in all health plans effective January 1, 2014. Further, as an essential benefit, as of September 23, 2010, insurers are to remove annual limits and phase out lifetime limitations over the next several years.

However, as of the date of this proposed rule, no specific federal guidance has been provided on how the MHPAEA and PPACA will be combined and what affect that combination will have on insurers and consumers. In the absence of such guidance, the commissioner's proposed rule does not interfere with an insurer's ability to comply with Wisconsin law, federal parity and federal health reform.

7. **Comparison of similar rules in adjacent states as found by OCI:**

Illinois: 214 Ill. Comp. Stat. Ann 5/370c, SB 1341, and HB 2190 provide minimum mandated benefits affecting group health policies having more than 50 enrolled employees. Covered conditions include serious mental illness, including pervasive developmental disorders and post-traumatic stress disorders. Benefits include a minimum of 45 inpatient days and 35 outpatient visits benefits for serious mental illness; other mental health conditions may be subject to 50% co-pays and the lesser of the annual limit of $10,000.00 or 25% of the lifetime policy limit. Mental illness resulting from the use of controlled substances or cannabis and addictions to controlled substances and cannabis are not required to be covered.

Iowa: Iowa code 514c.22 and HF420 provide minimum mandated benefits affecting group health policies having more than 50 enrolled employees. There is a 50-employee exemption if no coverage of mental illness is provided. Serious mental illness including pervasive developmental disorders and autistic disorders are covered; the minimum benefits include 30 inpatient days and 52 outpatient visits per plan year.

Michigan: SB 1209/Act 252 provides a minimum mandated benefit affecting Health Maintenance Organizations (HMOs) that covers broad-based mental health disorders and substance use disorders. Minimum coverage levels include a 3% cost exemption and no fewer than 20 outpatient mental health visits per plan year.

Minnesota: Minn. Stat. Sec. 62A.152, Minn. Stat. Sec. 62Q.47, and SB 845 provide

comprehensive parity for HMOs and Community Integrated Service Networks. Benefits are mandated if offered for individual and group policies. Broad-based mental health disorders and substance use disorders are covered at minimum coverage levels.

8. **A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

The commissioner appointed a 20-member advisory council that met two times to discuss implementation advice to the commissioner on the parity law, content and delivery of notices to employees and components of the actuarial study. The council membership includes Sen. Hansen and Rep. Pasch, the sponsors of Wisconsin's law as well as representatives from the insurance industry, mental health and hospital providers, consumer mental health and substance use disorder advocates, large and small businesses. The commissioner's staff also met with the Department of Health Services to ensure citations and coverage description reflects current transitional treatment provisions and updated regulations. The proposed rule reflects the results of the council's deliberations and advice.

9. **Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:**

Upon review of insurers affected by the regulation, the office identified no small businesses that would be affected by the regulation.

10. **See the attached Private Sector Fiscal Analysis.**

Private sector fiscal analysis is attached to the rule

11. **A description of the Effect on Small Business:**

No significant effect will be imposed on regulated small businesses. No additional technology requirements are necessary to comply with the regulation.

12. **Agency contact person:**

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110

Email: inger.williams@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Lynn A. Welsh
Legal Unit - OCI Rule Comment for Rule Ins 3375
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Lynn A. Welsh
Legal Unit - OCI Rule Comment for Rule Ins 3375
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53703-3474

Email address:

Lynn A. Welsh
lynn.welsh@wisconsin.gov

Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins. 3.37 (1) to (4) and (5) (intro.) are amended to read:

Ins 3.37 **(1)** PURPOSE. This section implements s. 632.89 (4) (a), Stats.

(2) APPLICABILITY. (a) This section applies to group and blanket disability insurance policies issued or renewed on and after November 1, 1992, and prior to December 1, 2010, and group health benefit plans and self-insured governmental plans that elect and are eligible to be exempt pursuant to s. 632.89 (3c), (3f) or (5), Stats., that provide coverage for inpatient hospital services or outpatient services, as defined in s. 632.89 (1) (d) or (e), Stats. Group and blanket disability insurance policies and exempted group health benefit plans and self-insured governmental plans shall cover transitional treatment services and comply with subs. (2m), (3), (4) and (5).

(b) Policies issued on or after December 1, 2010, by a group health benefit plan and a self-insured governmental health plan that are not otherwise exempt under s. 632.89 (3c), (3f) or (5), Stats., shall comply with subs. (2m), (3m), (4m) and (5m).

(3) COVERED SERVICES. AAn insurer offering a policy subject to this subsection shall provide at least the amount of coverage required under s. 632.89 (2) (dm) 2., 2007 Stats., subject to the exclusions or limitations, including deductibles and copayments, that are generally applicable to coverage required under s. 632.89 (2), 2007 Stats., for all of the following:

~~**Note:** Section 632.89 (2) (dm) 2., is repealed effective 12-1-10, by 2009 Wis. Act 218.~~

(a) Mental health services for adults in a day treatment program compliant with the services identified at s. DHS 61.75 (2) and offered by a provider certified by the department of health services under s. DHS 61.75.

(b) Mental health services for children and adolescents in a day treatment program compliant with the services identified at s. DHS 40.11 and offered by a provider certified by the department of health services under s. DHS 40.04.

(c) Services for persons with chronic mental illness provided through a community support program compliant with the services identified at s. DHS 63.11 and certified by the department of health services under s. DHS 63.03.

(d) Residential treatment programs compliant with the services identified at s. DHS 75.14 (1), for alcohol or drug dependent persons, or both, certified by the department of health services under s. DHS 75.14 ~~(1) and~~ (2) and under supervision as required in s. DHS 75.14 (5).

(e) Services for ~~alcoholism and other drug problems~~ substance use disorders provided in a day treatment program compliant with the services identified at s. DHS 75.12 (1), certified by the department of health services under s. DHS 75.12 ~~(1) and~~ (2) and under supervision as required in s. DHS 75.12 (5).

(f) Intensive outpatient programs for ~~the~~narcotic treatment ~~of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American society of addiction medicine~~ services for opiate addiction compliant with the services under s. DHS 75.15 (1) and (9), certified by the department of health services under s. DHS 75.15 (2) and under supervision as required in s. DHS 75.15 (4).

(g) Coordinated emergency mental health services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services are provided by a program compliant with s. DHS 34.22, certified by the department of health services under s. DHS 34.03, and provided in accordance with subch. III of ch. DHS 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other providers for stabilization. Certified emergency mental health service plans shall provide timely notice to third-party payors to facilitate coordination of services for persons who are experiencing or are in a situation likely to turn into a mental health crisis.

(4) OUT-OF-STATE SERVICES AND PROGRAMS. An insurer offering a group and blanket disability plan or exempt group health benefit plans and self-insured governmental plans may comply with sub. (3) (a) to (eg), by providing coverage for services and programs that are substantially similar to those specified in sub. (3) (a) to (eg), if the provider complies with similar requirements of the state in which the provider is located.

(5) POLICY FORM REQUIREMENTS. An insurer offering a group and blanket disability plan or exempt group health benefit plans and self-insured governmental plans shall specify in each policy form all of the following:

SECTION 2. Ins 3.37 (2m), (3m), (4m) and (5m) are created to read:

Ins 3.37 (2m) DEFINITIONS. The definitions contained in s. 632.89, Stats., and s. 3.375, shall also apply to this section.

(3m) COVERED SERVICES. An insurer offering a group health benefit plan or a self-funded governmental plan subject to this subs. shall provide coverage for services included in s. 632.89 (2) (dm), Stats., subject to the exclusions or limitations, including deductibles and copayments, that are generally applicable to coverage required under s. 632.89 (3), Stats., for all of the following:

(a) Mental health services for adults in a day treatment program compliant with the services identified at s. DHS 61.75 (2) and offered by a provider certified by the department of health services under s. DHS 61.75.

(b) Mental health services for children and adolescents in a day treatment program compliant with the services identified at s. DHS 40.11 and offered by a provider certified by the department of health services under s. DHS 40.04.

(c) Services for persons with chronic mental illness provided through a community support program compliant with the services identified at s. DHS 63.11 and certified by the department of health services under s. DHS 63.03.

(d) Residential treatment programs compliant with the services identified at s. DHS 75.14 (1), for alcohol or drug dependent persons, or both, certified by the department of health services under s. DHS 75.14 (2) and under supervision as required in s. DHS 75.14 (5).

(e) Services for substance use disorders provided in a day treatment program compliant with the services identified at s. DHS 75.12 (1), certified by the department of health services under s. DHS 75.12 (2) and under supervision as required in s. DHS 75.12 (5).

(f) Intensive outpatient programs for narcotic treatment service for opiate addiction compliant with the services under s. DHS 75.15 (1) and (9), certified by the department of health services under s. DHS 75.15 (2) and under supervision as required in s. DHS 75.15 (4).

(g) Coordinated emergency mental health services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services are provided by a program compliant with s. DHS 34.22, certified by the

department of health services under s. DHS 34.03, and provided in accordance with subch. III of ch. DHS 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other providers for stabilization. Certified emergency mental health service plans shall provide timely notice to third-party payors to facilitate coordination of services for persons who are experiencing or are in a situation likely to turn into a mental health crisis.

(4m) OUT-OF-STATE SERVICES AND PROGRAMS. An insurer offering a group health benefit plan and self-insured governmental health plan may comply with sub. (3m) (a) to (g) by providing coverage for services and programs that are substantially similar to those specified in sub. (3m) (a) to (g), if the provider complies with similar requirements of the state in which the provider is located.

(5m) POLICY FORM REQUIREMENTS. An insurer offering a group health benefits plan and self-insured governmental health plan shall specify in each policy form all of the following:

(a) The types of transitional treatment programs and services covered by the policy as specified in sub. (3m).

(b) The method the insurer and the self-insured governmental health plan uses to evaluate a transitional treatment program or service to determine if it is medically necessary and covered under the terms of the policy.

SECTION 3. Ins 3.375 is created to read:

Ins 3.375 (title) Ins 3.375. Coverage of nervous and mental disorders and substance use disorders.

(1) PURPOSE. This section interprets and implements s. 632.89, Stats.

(2) APPLICABILITY. (a) This section applies to group health benefit plans as defined in s. 632.745 (9), Stats., health benefit plans as defined in s. 632.745 (11), Stats., and self-insured governmental health plans as defined in s. 632.745 (24), Stats., unless otherwise excluded pursuant to s. 632.89 (5), Stats.

(b) For group health benefit plans and self-insured governmental plans covering employees who are affected by a collective bargaining agreement, the coverage under this section applies as follows:

1. If the collective bargaining agreement contains provisions consistent with s. 632.89, Stats., the coverage under this section first applies on the earliest of any of the following: the date the group health benefit plan is issued or renewed on or after December 1, 2010, or the date the self-insured governmental health plan is established, modified, extended or renewed on or after December 1, 2010.

2. If the collective bargaining agreement contains provisions inconsistent with s. 632.89, Stats., the coverage under this section applies on the earliest of any of the following: the date the collective bargaining agreement expires, or the date the collective bargaining agreement is extended, modified, or renewed.

(3) DEFINITIONS. In this section and for purposes of applying s. 632.89, Stats.:

(a) "Individual health benefit plan" means an insurance product offered on an individual basis that meets the criteria established for a health benefit plan in s. 632.745 (11), Stats.

(b)"Qualified actuary" means a member in good standing of the American academy of actuaries who meets any other requirements that the commissioner may by rule specify as defined in s. 623.06 (1c), Stat., and in accordance with s. 632.89 (3c) (b), Stats.

(c) "Self-insured governmental plan" has the meaning of a self-insured health plan as defined at s. 632.89 (1) (em), Stats.

(d) "Substance use disorder" has the same meaning as "alcoholism and other drug abuse problems" as the phrase appears throughout s. 632.89, Stats.

(e) "Substantially all" has the meaning as defined in 29 CFR 2590 § 2590.712 (c) (3) (i) (A).

(f) "Treatment limitations" means the limitations that insurers offering group or individual health benefit plans and self-insured governmental plans can impose on treatment of nervous and mental disorders and substance use disorders as described in s. 632.89 (3).

(4) INDIVIDUAL HEALTH BENEFIT PLANS. (a) Insurers offering health benefit plans on an individual basis that provide benefit coverage for the treatment of nervous and mental disorders or substance use disorders shall provide its criteria for determining medical necessity for coverage upon request and provide a detailed explanation of the reason for a benefit denial to the insured or the insured's authorized representative. The detailed explanation shall be in addition to the explanation of benefits required pursuant to s. 632.857, Stats.

(b) Insurers offering an individual health benefit plans that provide coverage of the treatment of nervous and mental disorders or substance use disorders may impose treatment limitations if the treatment limitations are no more restrictive than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan and in accordance with s. 632.89 (2), Stat., 29 CFR 2590 subpart C, and s. 2707 of Pub. L. 111-148, as applicable.

(c) Expenses incurred for the treatment of nervous and mental disorders or substance use disorders shall be included in any overall deductible amount, annual, lifetime, or out-of-pocket limits for the plan.

(5) LIMITATIONS. (a) Insurers offering group health benefit plans and self-insured governmental health plans that provide coverage of the treatment of nervous and mental disorders, and substance use disorders may impose treatment limitations. If treatment limitations are utilized by an insurer or self-insured governmental plan than the treatment limitations shall be no more restrictive than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan, in accordance with this section, s. 632.89 (2), Stat., 29 CFR 2590 subpart C, and s. 2707 of Pub. L. 111-148, as applicable.

(b) Expenses incurred for the treatment of nervous and mental disorders and substance use disorders shall be included in any overall deductible amount, annual, lifetime, or out-of-pocket limits for the plan.

(6) INCREASED COST EXEMPTION. (a) *Solely claims-experience rated employer.* At the request of an employer that is solely claims experience rated, an insurer offering a group health benefit plan shall have a qualified actuary determine whether the employer is eligible for a cost exemption based on the actual group claims experience in accordance with s. 632.89 (3c), Stats. Insurers can require employers to give at least 90-days advance notice to the insurer from the employer's renewal date for obtaining the determination.

1. The insurer shall request that the qualified actuary prepare an actuarial determination, provide copies of the actuarial determination and all underlying documents that the actuary relied upon in making the determination to the insurer. The insurer must provide the actuary's determination to the employer within 45 days of the employer's request.

2. The insurer shall be responsible for all expenses related to the actuarial cost increase determination and certification.

3. Both the insurer and the employer shall maintain the actuarial determination and underlying documentation for a period of not less than five years and in accordance with s. Ins. 6.80.

(b) *Combined pooled and claims experience rated employer.* An insurer offering a group health benefit plan shall have a qualified actuary determine whether the employer is eligible for an exemption in accordance with either of the following:

1. For an employer that is predominantly rated based on both its own claims experience and has less than 51% of the claims experience pooled with other group health plans, the calculation is to be based on the proportionate share applied due to actual group claims experience and the share applied due to the pooled experience and in accordance with s.

632.89 (3c), Stats. Insurers can require employers to give at least 90-days advance notice to the insurer from the employer's renewal date for obtaining the determination.

a. The insurer shall request that the qualified actuary prepare an actuarial determination, provide copies of the actuarial determination and all underlying documents that the actuary relied upon in making the determination to the insurer. The insurer must provide the actuary's determination to the employer within 45 days of the employer's request.

b. The insurer shall be responsible for all expenses related to the actuarial cost increase determination and certification.

c. Both the insurer and the employer shall maintain the actuarial determination and underlying documentation for a period of not less than five years and in accordance with s. Ins. 6.80.

2. For an employer that is predominantly rated based on claims experience pooled with other group health benefit plans that constitutes 51% or more of the claims experience, the insurer shall have a qualified actuary determine whether the pooled group is eligible for an exemption calculated based on the pool's claims experience and in accordance with s. 632.89 (3c), Stats. Insurers can require employers give at least 30-days advance notice to the insurer from the employer's renewal date for obtaining the determination.

1. The insurer shall have a qualified actuary calculate one time each year a determination of whether the employers participating within the pool are eligible for a cost exemption.

2. The insurer shall be responsible for all expenses related to the actuarial cost increase determination and certification.

3. The insurer shall make the determination available to an employer within 15 days of the employer's request. The insurer shall provide a date on which the actuarial determination

will be available annually. The insurer shall maintain the actuarial determination and underlying documentation for a period of not less than five years and in accordance with s. Ins. 6.80.

(c) *Prior and succeeding insurers.* During the first year after an employer changes insurers offering group health benefit plans, the succeeding insurer shall accept as accurate and may rely upon the prior insurer's determination of eligibility for cost exemption. A succeeding insurer shall provide the prior insurer's calculation to the employer following a timely request for purposes of calculating the employer's eligibility for a cost exemption.

(d) *Notice of election.* An insurer offering a group health benefit plan or a self-insured governmental health plan shall provide the applicable notice to the employer who qualifies for and elects an increased cost exemption under s. 632.89 (3c), Stats. The insurer shall inform the employer to notify promptly all enrollees under the plan of the exemption not to exceed 30-days following the cost increase determination and exemption election.

1. The notice shall be in substantially the form outlined in Appendix 2, using a standard typeface with at least a 10-point font, indicating the exemption election and that the plan will comply with benefit coverage requirements contained in s. 632.89 (2), 2007 Stats.

2. The notice shall be provided to each plan enrollee in either electronic or paper form.

3. The notice shall also be posted in a prominent position in each workplace of the employer.

(7) SMALL EMPLOYER EXEMPTION. (a) *Employer request.* An employer having fewer than 10 eligible employees on the first day of the plan year may request and elect an exemption from compliance with s. 632.89, Stats. An insurer offering a group health benefit plan or self-funded government plan shall inform the employer that in lieu of those requirements, the plan will cover benefits for nervous and mental disorders and substance use disorders in accordance with the requirements contained in s. 632.89 (2), 2007 Stats.

(b) *Notice of election.* An insurer offering a group health benefits plan or a self-insured governmental health plan shall provide the applicable notice to the employer who qualifies for and elects the small employer exemption under s. 632.89 (3f), Stats. The insurer shall inform the employer to notify promptly all enrollees under the plan of the exemption not to exceed 30 days from the employer's determination to elect exemption. The notice shall comply with all of the following:

1. The notice shall be in substantially the form outlined in Appendix 1, using a standard typeface with at least a 10-point font, indicating the exemption election and that the plan will cover benefits for nervous and mental disorders and substance use disorders in accordance with the requirements contained in s. 632.89 (2), 2007 Stats.

2. The notice shall be provided to each plan enrollee in either electronic or paper form.

3. The notice shall also be posted in a prominent position in each workplace of the employer.

SECTION 4. This section may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 5. These changes apply to policies issued or renewed on or after December 1, 2010.

SECTION 6. These emergency rule changes will take effect on November 29, 2010, as provided in s. 227.24(1)(c), Stats.

Dated at Madison, Wisconsin, this 22 day of November, 2010.

Sean Dilweg
Commissioner of Insurance

Small Employer Notice of the Plan's Election of Exemption from Mental Health and Substance Use Disorder Parity for [This Plan Year]

You are receiving this notice as an employee of [name of employer group]. This notice is to inform you that [name of employer group] qualifies and elects to be exempt from the state nervous and mental disorders and substance use disorders coverage parity requirements for this plan year, beginning [insert date of the first day of the plan year]. The employer is eligible to elect this exemption based upon having fewer than 10 eligible employees. Benefits may change as of [insert the date of the first day of the plan year].

Despite the exemption from the state nervous and mental disorders and substance use disorders coverage requirements, state law requires [name of employer group] to comply with the minimum mandated coverage requirements and limitations contained in s. 632.89 (2), 2007 Stats., for treatment services for nervous and mental disorders and substance use disorders.

For this plan year, your plan provides the following coverage related to nervous and mental disorders and substance use disorders:

[Insert plain language benefits summary]

Carefully review your health plan's benefits, limitations, and exclusions for detailed information on services and coverage available to you and your family this plan year. If you have additional questions please contact [insert contact name, phone number and e-mail address if available].

Ins 3.375 Appendix 2

Group Health Benefit Plan Notice of Election of Exemption from Mental Health and Substance Use Disorder Parity for [This Plan Year]

You are receiving this notice as an employee of [name of employer group]. This notice is to inform you that [name of employer group] qualifies and elects to be exempt from the state nervous and mental disorders and substance use disorders coverage parity requirements for this plan year, beginning [insert date of the first day of the plan year].

A group health benefit plan may elect to be exempt from mental health and substance use disorder parity if there are increases in the employer's total cost of coverage for the treatment of physical conditions and nervous and mental disorders and substance use disorders by a percentage that exceeds either two percent (2%) in the first plan year in which the nervous and mental disorders and substance use disorders coverage requirements apply or one percent (1%) in any plan year after the first plan year in which the requirements apply. Benefits may change as of [insert the date of the first day of the plan year].

Despite the exemption from the state nervous and mental disorders and substance use disorders coverage requirements, state law requires [name of employer group] to comply with the minimum mandated coverage requirements and limitations contained in s. 632.89 (2), 2007 Stats., for treatment services for nervous and mental disorders and substance use disorders..

For this plan year, your plan provides the following coverage related to nervous and mental disorders and substance use disorders:

[Insert plain language benefits summary]

Carefully review your health plan's benefits, limitations, and exclusions for detailed information on services and coverage available to you and your family this plan year. If you have additional questions please contact [insert contact name, phone number and e-mail address if available].

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

Section Ins 3.375 relating to health insurance coverage of nervous and mental disorders and substance use disorders, and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.

Division of Executive Budget and Finance
DOA-2047 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 3375**

Subject
health insurance coverage of nervous and mental disorders and substance use disorders, and affecting small business

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	Annualized Fiscal impact on State funds from: Increased Costs	Decreased Costs
A. State Costs by Category		
State Operations - Salaries and Fringes	$ 0	$ -0
(FTE Position Changes)	(0 FTE)	(-0 FTE)
State Operations - Other Costs	0	-0
Local Assistance	0	-0
Aids to Individuals or Organizations	0	-0
TOTAL State Costs by Category	$ 0	$ -0
B. State Costs by Source of Funds	Increased Costs	Decreased Costs
GPR	$ 0	$ -0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	Increased Rev.	Decreased Rev.
GPR Taxes	$ 0	$ -0
GPR Earned	0	-0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
TOTAL State Revenues	$ 0 None	$ -0 None

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ None 0	$ None 0
NET CHANGE IN REVENUES	$ None 0	$ None 0

Prepared by:	Telephone No.	Agency
Lynn A. Welsh	(608) 261-8565	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)
		11/22/2010

Division of Executive Budget and Finance
DOA-2048 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 3375**

Subject

health insurance coverage of nervous and mental disorders and substance use disorders and affecting small business

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues

☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues

☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others ____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected ☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by:	Telephone No.	Agency
Lynn A. Welsh	(608) 261-8565	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)
		11/22/2010