State of Wisconsin
2005 – 2006 LEGISLATURE

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SENATE SUBSTITUTE AMENDMENT 1,

TO 2005 SENATE BILL 128

December 19, 2005 – Offered by COMMITTEE ON HEALTH, CHILDREN, FAMILIES, AGING AND LONG TERM CARE.

AN ACT ***to amend*** 632.89 (2) (b) 1., 632.89 (2) (b) 2., 632.89 (2) (c) 2. (intro.), 632.89 (2) (c) 2. b., 632.89 (2) (d) 2. and 632.89 (2) (dm) 2.; and ***to create*** 632.89 (1) (am) and 632.89 (2) (f) of the statutes; **relating to:** increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems.

Analysis by the Legislative Reference Bureau

Under current law, a group health insurance policy (called a "disability insurance policy" in the statutes) that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems 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 nervous and mental disorders and alcoholism and other drug 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 (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) for the treatment of nervous and mental disorders and alcoholism and other drug 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. If a group health insurance policy provides coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems need not exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year.

This bill changes the minimum amount of coverage that must be provided for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems on a gradual basis over a five–year period, from 2007 to 2011, by increasing the minimum amount each year by the same amount. For example, inpatient services for policies issued or renewed in 2007 must be covered in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $9,260 minus the applicable cost sharing or, if there is no cost sharing under the policy, $8,340 in equivalent benefits measured in services rendered, while inpatient services for policies issued or renewed in 2011 must be covered in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $18,300 minus the applicable cost sharing or, if there is no cost sharing under the policy, $16,500 in equivalent benefits measured in services rendered. Outpatient services for policies issued or renewed in 2011 must be covered in the minimum amount of $3,100 minus the applicable cost sharing or, if there is no cost sharing under the policy, $2,800 in equivalent benefits measured in services rendered. Transitional treatment arrangements for policies issued or renewed in 2011 must be covered in the minimum amount of $4,700 minus the applicable cost sharing or, if there is no cost sharing under the policy, $4,200 in equivalent benefits measured in services rendered. The total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems need not exceed, in a policy year, $9,260 for policies issued or renewed in 2007, $11,520 for policies issued or renewed in 2008, $13,780 for policies issued or renewed in 2009, $16,040 for policies issued or renewed in 2010, or $18,300 for policies issued or renewed in or after 2011, or the equivalent benefits measured in services rendered.

The bill also requires the Department of Health and Family Services to report annually to the governor and legislature, beginning in 2007, on the change in coverage limits necessary to conform with the change in the federal consumer price index for medical costs.

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

SECTION 1. 632.89 (1) (am) of the statutes is created to read:

632.89 **(1)** (am) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

SECTION 2. 632.89 (2) (b) 1. of the statutes is amended to read:

632.89 **(2)** (b) 1. Except as provided in subd. 2., if a group or blanket disability insurance policy issued by an insurer provides coverage of inpatient hospital treatment or outpatient treatment or both, the policy shall provide coverage in ~~every~~ a policy year as provided in pars. (c) to (dm), as appropriate, except that the total coverage under the policy for a policy year need not exceed ~~$7,000~~ $9,260 for a policy issued or renewed in 2007, $11,520 for a policy issued or renewed in 2008, $13,780 for a policy issued or renewed in 2009, $16,040 for a policy issued or renewed in 2010, or $18,300 for a policy issued or renewed in or after 2011, or the equivalent benefits measured in services rendered.

SECTION 3. 632.89 (2) (b) 2. of the statutes is amended to read:

632.89 **(2)** (b) 2. ~~The~~ An amount under subd. 1. may be reduced if the policy is written in combination with major medical coverage to the extent that results in combined coverage complying with subd. 1.

SECTION 4. 632.89 (2) (c) 2. (intro.) of the statutes is amended to read:

632.89 **(2)** (c) 2. (intro.) Except as provided in par. (b), a policy under subd. 1. shall provide coverage in ~~every~~ a policy year for not less than the lesser of the following:

SECTION 5. 632.89 (2) (c) 2. b. of the statutes is amended to read:

632.89 **(2)** (c) 2. b. ~~Seven thousand~~ Nine thousand two hundred sixty dollars for a policy issued or renewed in 2007, $11,520 for a policy issued or renewed in 2008, $13,780 for a policy issued or renewed in 2009, $16,040 for a policy issued or renewed in 2010, and $18,300 for a policy issued or renewed in or after 2011, minus any

applicable cost sharing at the level charged under the policy for inpatient hospital services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$6,300~~ $8,340 for a policy issued or renewed in 2007, $10,380 for a policy issued or renewed in 2008, $12,420 for a policy issued or renewed in 2009, $14,460 for a policy issued or renewed in 2010, and $16,500 for a policy issued or renewed in or after 2011 in equivalent benefits measured in services rendered.

SECTION 6. 632.89 (2) (d) 2. of the statutes is amended to read:

632.89 **(2)** (d) 2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in ~~every~~ a policy year for not less than ~~$2,000~~ $2,220 for a policy issued or renewed in 2007, $2,440 for a policy issued or renewed in 2008, $2,660 for a policy issued or renewed in 2009, $2,880 for a policy issued or renewed in 2010, and $3,100 for a policy issued or renewed in or after 2011, minus any applicable cost sharing at the level charged under the policy for outpatient services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$1,800~~ $2,000 for a policy issued or renewed in 2007, $2,200 for a policy issued or renewed in 2008, $2,400 for a policy issued or renewed in 2009, $2,600 for a policy issued or renewed in 2010, and $2,800 for a policy issued or renewed in or after 2011 in equivalent benefits measured in services rendered.

SECTION 7. 632.89 (2) (dm) 2. of the statutes is amended to read:

632.89 **(2)** (dm) 2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in ~~every~~ a policy year for not less than ~~$3,000~~ $3,340 for a policy issued or renewed in 2007, $3,680 for a policy issued or renewed in 2008, $4,020 for a policy issued or renewed in 2009, $4,360 for a policy issued or renewed in 2010, and $4,700 for a policy issued or renewed in or after 2011, minus any applicable cost sharing at the level charged under the policy for transitional treatment

arrangements or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$2,700~~ $3,000 for a policy issued or renewed in 2007, $3,300 for a policy issued or renewed in 2008, $3,600 for a policy issued or renewed in 2009, $3,900 for a policy issued or renewed in 2010, and $4,200 for a policy issued or renewed in or after 2011 in equivalent benefits measured in services rendered.

SECTION 8. 632.89 (2) (f) of the statutes is created to read:

632.89 **(2)** (f) *Report on coverage limits.* Beginning in 2007, the department of health and family services shall report annually to the governor and the legislature on revising the coverage limits specified in this subsection based on the change in the consumer price index for medical costs.

(END)