WISCONSIN LEGISLATIVE COUNCIL
ACT MEMO

2009 Wisconsin Act 218 **[2009 Senate Bill 362]**	**Mental Health Parity**

This memorandum summarizes 2009 Wisconsin Act 218, which relates to parity in insurance coverage of nervous and mental disorders, alcoholism, and other drug abuse problems. Also, for background purposes, the memorandum summarizes a federal law on this issue that was enacted in 2008, and Wisconsin statutes in effect before Act 218 that required a minimum level of coverage for these disorders.

Federal Wellstone-Domenici Act

This portion of the memorandum summarizes the provisions of a federal law relating to group health plans. The law was part of P.L. 110-343; Title V, Subtitle B of that public law was entitled the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (referred to in this memorandum as "the Wellstone-Domenici Act").

The Wellstone-Domenici Act amends 29 U.S.C. s. 1185a., which is part of the Employee Retirement Income Security Act (ERISA) and affects group health plans. (In this memorandum, the term group health plan also includes health insurance coverage offered in connection with such a plan.) If a plan offers medical and surgical benefits and also offers mental health or substance use disorder benefits, the plan must ensure that the following requirements are met:

- The **financial requirements** applicable to the mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements applied to substantially all the medical and surgical benefits that are covered, and there must be no separate cost-sharing requirements that are applicable only to mental health or substance use disorder benefits.

- The **treatment limitations** applicable to the mental health or substance use disorder benefits must be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits that are covered, and there must be no separate

One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
(608) 266-1304 • Fax: (608) 266-3830 • Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc

treatment limitations that are applicable only to mental health or substance use disorder benefits.

For purposes of the above provisions, the law defines the terms "financial requirement", "predominant", and "treatment limitation". The term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses. While the term excludes aggregate lifetime limits and annual limits, ERISA provisions (for which the Wellstone-Domenici Act removes the sunset clause) affect those limits. The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. A financial requirement or treatment limit is considered to be "predominant" if it is the most common or frequent of such type of limit or requirement.

The criteria for **medical necessity** determinations made under the plan with respect to mental health or substance use disorder benefits must be made available in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial with respect to payment for those services must, on request or as otherwise required, be made available to the participant or beneficiary in accordance with regulations.

If a plan that is subject to the law covers medical or surgical benefits provided by out-of-network providers, the plan must cover mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the law.

The law does not apply to small employers, a term that is defined to mean an employer with **50 or fewer employees** on business days during the preceding calendar year.

In addition, the law does not apply to a group health plan if the application of the law to the plan results in an increase in total actual costs by an amount that exceeds the applicable percentage described in the law (although the employer may elect to continue to apply the parity provisions regardless of any increase in total costs). The applicable percentage is 2% for the first plan year, and 1% for every subsequent plan year. Determinations of increases in actual costs must be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. If a plan seeks an exemption under this provision, it must be made after the plan has complied with the requirements for the first six months of the plan year involved. The exemption then applies in the subsequent plan year. The plan must promptly notify the Secretary of Labor, the appropriate state agencies, and participants and beneficiaries in the plan. The notice to the Secretary of Labor must include specified information. The Secretary of Labor is given the authority to audit the books and records of a plan relating to such an exemption.

The law requires the Secretary of Labor, in cooperation with the Secretary of Health and Human Services, and the Secretary of the Treasury, to publish and widely disseminate guidance and information for group health plans, participants and beneficiaries, applicable state and local regulatory bodies, and the National Association of Insurance Commissioners, regarding the requirements of the law and to provide assistance concerning the requirements and the continued operation of applicable state law.

The Wellstone-Domenici Act, in addition to amending ERISA, also amends the Public Health Service Act and the Internal Revenue Code to include similar provisions. In addition, the law requires the secretaries of the three agencies to issue **regulations** to carry out the law. Those secretaries may ensure, through the execution or revision of an interagency memorandum of understanding, that: (1) regulations, rulings, interpretations issued by the secretaries relating to the same matter over which two or more such secretaries have responsibility are administered so as to have the same effect at all times;

and (2) coordination of policies relating to enforcing the same requirements avoids duplication of enforcement efforts and assigns priorities in enforcement.

Wisconsin Law Prior to Act 218

Wisconsin statutes prior to Act 218 require a group or blanket disability insurance policy to provide coverage of nervous and mental disorders and alcoholism and other drug abuse conditions (referred to in this memorandum as "mental health/AODA") as follows:

- If the policy provides coverage of any inpatient hospital treatment, it must provide coverage for inpatient hospital services for the treatment of mental health/AODA conditions for at least the lesser of: (1) the expenses of 30 days as an inpatient in a hospital; or (2) $7,000 or the equivalent in services rendered minus any applicable cost-sharing, or $6,300 in services rendered if the policy does not use cost-sharing.

- If the policy provides coverage of any outpatient treatment, it must provide coverage for outpatient services for the treatment of mental health/AODA conditions for not less than $2,000 minus any applicable cost-sharing at the level charged for outpatient services or the equivalent in services rendered or, $1,800 in equivalent benefits if the policy does not use cost-sharing.

- If the policy provides coverage of any inpatient hospital treatment or any outpatient treatment, it must provide coverage for transitional treatment for not less than $3,000 minus any applicable cost-sharing or the equivalent in services rendered or $2,700 in equivalent benefits if the policy does not use cost-sharing.

Notwithstanding the above dollar amounts, the policy is not required to provide total coverage for mental health/AODA conditions in excess of $7,000 or the equivalent benefits measured in services rendered. Also, coverage of those conditions may be subject to exclusions or limitations, including deductibles and copayments, that are generally applicable to other conditions covered under the policy.

The law defines such terms as "inpatient hospital services," "outpatient services," and "transitional treatment arrangements." Because of the definition of "outpatient services," the statute on outpatient services applies to mental health/AODA services rendered by: (1) a program in a outpatient treatment facility subject to specified state requirements; (2) a licensed physician who has completed a residency in psychiatry; (3) a licensed psychologist; or (4) a licensed mental health professional (defined as a clinical social worker, a marriage and family therapist, or a professional counselor, licensed under ch. 457, Stats.).

Unlike the Wellstone-Domenici Act, this Wisconsin law is not limited to groups that are above a certain number of employees. However, Wisconsin law does not cover private employer self-insured plans because of preemption by ERISA.

2009 Wisconsin Act 218

Act 218 makes a number of changes in prior law with respect to mental health/AODA coverage. The Act retains the provisions in the law that require group insurers to provide coverage of mental health/AODA services if they provide coverage of other specified services. The law changes the reference from group or blanket disability insurance policies to group health benefit plans and governmental self-insured health plans.

In addition, the Act repeals the minimum dollar coverage amounts specified in current law. Instead, the Act specifies that for a group health benefit plan and a governmental self-insured health plan that provides coverage for mental health/AODA conditions, and for an individual health plan that provides coverage for these conditions, the exclusions and limitations; deductibles; copayments; coinsurance; annual and lifetime payment limitations; out-of-pocket limits; out-of-network charges; day, visit, or appointment limits; limitations regarding referrals to nonphysician providers and treatment programs; and duration or frequency of coverage limits under the plan; may be **no more restrictive** for coverage of the treatment of mental health/AODA conditions **than the most common or frequent type of treatment limitations applied to substantially all other coverage** under the plan. In addition, the Act specifies that the plan must include in any overall deductible amount or annual or lifetime limit or out-of-pocket limit for the plan, expenses incurred for treatment of mental health/AODA conditions.

Act 218 includes the following exemptions to those parity requirements:

- A group health benefit plan or a governmental self-insured health plan that provides coverage for mental health/AODA conditions may elect to be exempt from the parity requirements under the Act during any plan year following any plan year in which, as a result of the parity requirements, there is an increase under the plan in the total cost of coverage for the treatment of physical conditions and mental health/AODA conditions that exceeds 2% in the first plan year in which those requirements apply, or 1% in subsequent plan years. The cost increase may not be determined until the plan has complied with the requirements for at least the first six months of the plan year for which the increase is to be determined. In addition, the cost increase must be determined and certified by a qualified actuary. The plan must notify all enrollees that it has elected to be exempt. If a plan elects to be exempt from the parity requirements, the plan is subject to the minimum dollar coverage amounts specified in prior Wisconsin law.

- An employer that provides health care coverage for its employees though a group health benefit plan may elect to be exempt from the parity requirements during a plan year if, on the first day of the plan year, the employer will have fewer than 10 eligible employees. A plan that qualifies for this exemption must notify all enrollees that it has elected to be exempt. If a plan elects to be exempt from the parity requirements, the plan is subject to the minimum dollar coverage amounts specified in prior Wisconsin law.

The Act also creates a new provision that states that a group health benefit plan, a governmental self-insured health plan, and an individual health benefit plan, that provides coverage for the treatment of mental health/AODA conditions, **must make available the criteria for determining medical necessity** under the plan with respect to that coverage. The criteria must be made available, upon request, to any current or potential insured, participant, beneficiary, or contracting provider. Also, the Act provides that if a group health benefit plan or a governmental self-insured health plan that provides coverage for mental health/AODA conditions denies any particular insured, participant, or beneficiary coverage for services for that treatment, or if an individual health benefit plan that provides coverage for

these conditions denies any particular insured coverage for services for that treatment, the plan must, upon request, make the reason for the denial available to those persons. This requirement is in addition to complying with current law with respect to explaining restrictions or terminations of coverage.

The Act provides that the law on mental health/AODA coverage does not apply to coverage of autism spectrum disorder. Coverage requirements for that disorder are set forth in a different section of current law.

The Commissioner of Insurance is required to promulgate rules for administration of the mental health/AODA coverage law, including rules specifying information in the notices to be given to enrollees under the exemptions described above and the manner in which those notices must be given, specifying who is responsible for the actuarial study and cost-increase determination, and specifying retention requirements for the cost-increase determination and underlying documentation. In promulgating the rules, the Commissioner of Insurance must follow, as a minimum standard, any relevant federal regulations or guidelines that are in effect. The rules may be promulgated using the rule-making procedure used to promulgate emergency rules.

Effective date: The Act takes effect on December 1, 2010. It applies to health benefit plans that are issued or renewed on or after that date and governmental self-insured plans that are established, extended, modified, or renewed on or after that date, subject to any collective bargaining agreements.

Prepared by: Richard Sweet, Senior Staff Attorney May 6, 2010

RNS:jal