

Fact Sheet on Mandated Benefits for the Treatment of Nervous and Mental Disorders or Substance Use Disorders

OFFICE OF THE COMMISSIONER OF INSURANCE

PI-008 (R 03/2011)

The Wisconsin Office of the Commissioner of Insurance has prepared this guide to assist health care providers and insurers in understanding and applying Wisconsin's mandated health care benefits law as it relates to the treatment of nervous and mental disorders or substance use disorders. This guide also discusses the federal Mental Health Parity Act of 1996, as well as the Mental Health Parity and Addiction Equity Act of 2008.

Please refer questions to:

Department of Health Services
1 West Wilson Street
Madison, Wisconsin 53702
(608) 266-1865

or

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-0103 (In Madison)
1-800-236-8517 (Statewide)

Wisconsin law requires that certain health insurance policies include inpatient, outpatient, and transitional benefits to treat nervous and mental disorders and substance use disorders. [s. 632.89, Wis. Stat.]

To what policies or plans does the law apply?

This law applies to group health insurance policies and contracts, self-insured governmental health plans, and individual health policies issued in Wisconsin that provide coverage of nervous and mental health disorders or substance use disorders.

These mandated benefits are not required in:

- Individual insurance policies; however, if an insurer elects to offer coverage, it must be done on a parity basis;
- Federal employee group plans (e.g., postal carrier's plans);
- Self-insured employer group plans falling within the terms of the federal Employee Retirement Income Security Act (ERISA) of 1974; and
- Most policies issued to a group based in another state if both the policyholder and group exist primarily for purposes other than to procure insurance and fewer than 25% of the insured persons are Wisconsin residents.

What services are covered by the law?

There are three services covered by the law:

- *Inpatient Services.* These are services for the treatment of nervous and mental disorders or substance use disorders that are provided to an insured in a hospital.
- *Outpatient Services.* These are nonresidential services for the treatment of nervous and mental disorders or substance use disorders that are provided to an insured by any of the following entities or persons or, if for the purpose of enhancing the treatment of the insured, a collateral of the insured:
 - A program in an outpatient treatment facility that has been approved by the Department of Health Services and established and maintained according to rules promulgated under s. 51.42 (7) (b), Wis. Stat.

- A licensed physician who has completed a residency in psychiatry in an outpatient treatment facility or in the physician’s office.
- A licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or who is certified by the American Board of Professional Psychology.
- *Transitional Treatment Services.* These are services for the treatment of nervous or mental disorders or substance use disorders that are provided to an insured in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services [s. Ins 3.37 (3m), Wis. Adm. Code].

Must all plans and policies to which the law applies provide both inpatient and outpatient services?

Yes. However, 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 disorders or substance use disorders must make available the criteria for determining medical necessity under the plan with respect to that coverage.

Additionally, if a group health benefit plan or a governmental self-insured health plan that provides coverage for mental health disorders or substance use disorders 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.

What types of coverage must be provided in plans subject to the law?

Required coverages are for the treatment of nervous and mental disorders or substance use disorders.

The law does not apply to coverage of autism spectrum disorders or limited service health organizations and does not duplicate coverage available through Medicare [s. 632.89 (5), Wis. Stat.].

What is the minimum coverage that must be provided in every policy year?

The law specifies that for a group health benefit plan, a governmental self-insured health plan, and an individual health plan that provides coverage for nervous and mental health disorders or substance use disorders, the exclusions and limitations; deductibles; copayments; coinsurance; annual and lifetime payment limitations; out-of-pocket limits; out-of-network charges; day, visit, or appointment limits; limitations regarding referrals to nonphysician providers and treatment programs; and duration or frequency of coverage limits under the plan may be no more restrictive for coverage of the treatment of nervous and mental health disorders or substance use disorders than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan.

Do copayment requirements and deductibles of the policy apply to these mandated benefits?

Yes, an insurer may apply the same deductible amount and/or copayment amount to mental health disorders or substance use disorders that apply to all other benefits.

Outpatient services will cover treatment provided to a collateral if the treatment was rendered for the purpose of enhancing the treatment to the insured. What is the meaning of a “collateral”?

A “collateral” means a member of an insured’s immediate family and is limited to the spouse, children, parents, grandparents, brothers, and sisters of the insured and their spouses.

Some group policies set waiting periods for preexisting conditions. How is the date of onset of a nervous or mental disorder or substance use disorder to be determined to judge whether the condition is a preexisting condition for insurance purposes?

An insurer may apply a waiting period for a preexisting condition if it has evidence that the disease existed prior to coverage under the policy. Sufficient evidence would be a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment in the health plan.

May benefits be paid under more than one plan?

Benefits can be paid under more than one plan. However, most group plans contain a coordination (or duplication) of benefits provision that is intended to limit the payment of benefits under all coverage to 100% of the total covered expenses.

Does the requirement for coverage of outpatient treatment prohibit any limitation on the amount of a provider's charge to be covered, e.g., application of a "usual and customary fees" limitation that would generally be applicable to other covered conditions?

No, if the basis an insurer uses to establish fee reimbursement levels is reasonable and equitably applied to all providers.

Are prescription drugs included as part of the mandated coverage for the treatment of nervous and mental disorders or substance use disorders?

Yes, but only if prescription drug coverage is provided as part of the insurance plan. Prescription drugs are covered if the drugs are prescribed for a patient who is receiving treatment on either an inpatient or outpatient basis and if the prescription drugs are for the treatment of nervous and mental disorders or substance use disorders. The costs incurred for the prescription drugs or diagnostic testing cannot be applied toward the minimum coverage for either inpatient or outpatient treatment. If a health plan does not provide coverage for prescription drugs, then they are not included as part of the mandated coverage.

When did this law become effective? Does it apply to policies and contracts in force at that time or only to those issued after that date?

This law was effective 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.

What is the Mental Health Parity Act of 1996?

The federal Mental Health Parity Act (MHPA) was signed into law on September 26, 1996. MHPA provides for parity in the application of aggregate

lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. MHPA's provisions are subject to concurrent jurisdiction by the Department of Labor, the Treasury, and the Department of Health and Human Services.

The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded existing requirements under the MHPA of 1996.

How will the federal Mental Health Parity and Addiction Equity Act affect mental health benefits?

Under MHPAEA, group health plans, insurance companies, and health maintenance organizations (HMOs) offering mental health benefits will no longer be allowed to set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan. MHPAEA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

Does the requirement apply to all group health plans?

No. Health plans are not required to include mental health in their benefits package. The requirements under the federal MHPAEA apply only to plans offering mental health benefits in the self-funded and large group markets. Federal law doesn't require plans to include mental health benefits in their package.

However, the state law, s. 632.89, Wis. Stat., does apply to a group health benefit plan, a governmental self-insured health plan, and an individual health benefit plan to the extent such coverages are included.

May an insurer impose restrictions on mental health benefits?

Yes. Like state law, insurers will be able to set the terms and conditions, including cost-sharing and limits on the number of visits or days of coverage for the amount, duration, and scope of mental health benefits. However, these benefits must be no more restrictive for coverage of the

treatment of mental health disorders or substance use disorders conditions than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan.

Do all group health plans offering mental health benefits have to meet the parity requirements?

No. There are two exceptions to these federal laws.

- The mental health parity requirements do not apply to small employers who have fewer than 51 employees.
- Any group health plan whose costs increase 2% or more the first year and 1% for every subsequent year due to the application of MHPAEA's requirements may claim an exemption from MHPAEA's requirements.

The same exemption is available under state law. However, if it is exempt, state law requires compliance with the minimum mandated coverage requirements and limitations contained in s. 632.89 (2), (2007) Wis. Stat.

When did this law become effective?

The mental health parity requirements apply to self-funded and large group health plans for plan years beginning on or after October 3, 2009. Plans offered on a calendar year basis or those beginning early in 2009 were provided a transition period until January 1, 2010.

If a provider or patient has a question about whether a claim for insurance benefits has been handled properly, contact the Office of the Commissioner of Insurance describing the problem. Include the name of the insurance company, the group policy number, and the subscriber or certificate number. Send the complaint to:

Information and Complaints Section
Office of the Commissioner of Insurance (OCI)
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0103 (In Madison)
1-800-236-8517 (Statewide)

How to Find Out More

If you have additional questions regarding the federal Mental Health Parity and Addiction Equity Act, please contact:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attn: CMS-4137-NC
P.O. Box 8017
Baltimore, MD 21244-8010
1-800-633-4227
1-877-486-2048 TTY
www.cms.gov

-or-

Employee Benefits Security Administration
(EBSA)
U.S. Department of Labor (DOL)
200 Constitution Avenue, N.W.
Washington, DC 20210
1-866-4-USA-DOL (1-866-487-2365)
1-877-889-5627 TTY
www.dol.gov/dol/topic/health-plans/

For information on how to file insurance complaints call:

(608) 266-0103 (Madison)
or
1-800-236-8517 (statewide)

Mailing Address

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Electronic Mail

ocicomplaints@wisconsin.gov
(please indicate your name, phone number, and e-mail address)

OCI's World Wide Web Home Page
oci.wi.gov

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