

Fact Sheet on Mandated Benefits for the Treatment of NERVOUS and MENTAL DISORDERS or SUBSTANCE USE DISORDERS

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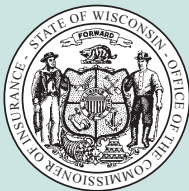
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This guide is meant to assist health care providers and insurers in understanding and applying mandated health care benefits law as it relates to the treatment of nervous and mental disorders or substance use disorders. Furthermore, this guide discusses Wisconsin law, the federal Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equity Act of 2008, and the Affordable Care Act.

What policies or plans must cover the treatment of nervous and mental disorders or substance abuse disorders?

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

Wisconsin law applies to individual insurance policies only to the extent an insurer elects to offer coverage; it must be done on a parity basis. Federal employee group plans (e.g., postal carrier's plans) and self-insured employer group plans falling within the terms of the federal Employee Retirement Income Security Act (ERISA) of 1974 are exempt from the Wisconsin law. Wisconsin law does not apply to 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 if fewer than 25% of the insured persons are Wisconsin residents.

The federal Mental Health Parity Act (MHPA), which was enacted in 1996, 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 does not apply to substance use disorder 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 these requirements, including extending parity rules to substance use disorder benefits. Under MHPAEA, group health plans, insurance companies, and health maintenance organizations (HMOs) offering mental health benefits may not set annual or lifetime dollar limits on mental health benefits lower than any such dollar limits for medical and surgical benefits. A plan not imposing 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 does not require health plans to include mental health in their benefits package. MHPAEA requirements apply only to plans offering mental health benefits in the self-funded and large group markets. Federal law does not require plans to include mental health and substance use disorder benefits in their benefit package.

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Effective January 1, 2014, the federal Affordable Care Act (ACA) requires all non-grandfathered¹ individual and small employer plans (1 to 50 employees) to cover the treatment of nervous and mental disorders or substance abuse disorders as an “essential health benefit” (EHB). The coverage must be provided on a parity basis per MHPAEA and, as an EHB, not be subject to any annual or lifetime dollar limits.

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

No. 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 contained in s. 632.89 (2), Wis. Stat.

May an insurer impose restrictions on mental health benefits?

Yes. Insurers may set 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.

What services must be covered?

Three services must be covered:

Inpatient Services

These are services for the treatment of nervous and mental disorders or substance use disorders 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 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 approved by the Wisconsin Department of Health Services (DHS) 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 psychologist licensed under ch. 455, Wis. Stat.
- A licensed mental health professional practicing within the scope of his or her license under ch. 457, Wis. Stat., and applicable rules

Transitional Treatment Services

These are services for the treatment of nervous or mental disorders or substance use disorders 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]. Programs providing these services are certified by Wisconsin DHS.

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 providing 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 mental health disorders or substance use disorders are covered by a group health benefit plan, a governmental self-insured health plan, or an individual health benefit plan, and that plan denies coverage for the treatment of these conditions to a particular insured, participant, or beneficiary, they must, upon request, provide a reason for the denial. This requirement is in addition to complying with current law dealing with explanation of restrictions or terminations of coverage.

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

Coverage of the treatment of nervous and mental health disorders or substance use disorders may be no more restrictive than the most common or frequent

¹ A “non-grandfathered plan” is a health plan established after the ACA was enacted or a health plan changed in one or more specified ways since the law's enactment.

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type of treatment limitations applied to substantially all other coverage under the plan. This includes:

- 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 non-physician providers and treatment programs

duration or frequency of coverage limits

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 as applied to all other benefits.

What is the meaning of "a collateral"—

"Outpatient services will cover treatment provided to a collateral if the treatment was rendered for the purpose of enhancing the treatment to the insured."

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.

May benefits be paid under more than one plan?

Yes, benefits may be paid under more than one plan. However, most group plans contain a coordination (or duplication) of benefits provision 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 are 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. If prescription drug coverage is provided, the coverage applies to both inpatient and outpatient treatment of nervous and mental disorders or substance use disorders.

How to Find Out More

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(800) 236-8517 (statewide)
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For questions regarding the federal Mental Health Parity and Addiction Equity Act, please contact:

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Centers for Medicare & Medicaid Services**
Attn: CMS-4137-NC
P.O. Box 8017
Baltimore, MD 21244-8010
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(877) 486-2048 TTY
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Washington, DC 20210
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