CR 92-132

STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

I, John W. Torgerson, Deputy Commissioner and custodian of the official records of this office, certify that the attached rule-making order affecting s. Ins 3.37, Wis. Adm. Code, relating to specifying the transitional treatment services for nervous or mental diseases or alcoholism or other drug dependence that health insurance must cover, was issued by this office on January 11, 1993.

I further certify that I have compared this copy with the original on file in this office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 11th day of January 1993.

John W. Torgerson
Deputy Commissioner

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RECEIVED
JAN 12 1993
2:45 pm
Revisor of Statutes
Bureau

STATE OF WISCONSIN
RECEIVED & FILED
JAN 11 1993
DOUGLAS LA FOLLETTE
SECRETARY OF STATE

3-1-93

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create s. Ins 3.37, relating to specifying the transitional treatment services for nervous or mental diseases or alcoholism or other drug abuse problems that health insurance must cover.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3) and 632.89 (4), Stats.

Statutes Interpreted: s. 632.89 (1) (f) and (2) (dm), Stats.

1991 Wisconsin Act 250 requires group and blanket disability insurance policies that provide coverage for any inpatient hospital treatment or any outpatient treatment to also provide coverage for transitional treatment arrangements for nervous or mental disorders or alcoholism or other drug abuse (AODA). Transitional treatment arrangements are described by statute as services provided to an insured in a less restrictive manner than inpatient hospital services but in a more intensive manner than are outpatient services. The commissioner of insurance is required to specify the covered services by rule.

This rule was drafted after receiving comments from department of health and social services staff, mental health and AODA service providers, health insurers and community organizations.

This rule requires that a policy subject to this rule provide at least the amount of coverage required by the statute ($2,700, or the equivalent amount in services provided by a health maintenance organization) for services provided for the treatment of AODA in a day treatment or residential treatment program certified by the department of health and social services (DHSS). Day treatment programs, which are operated by certified inpatient and outpatient AODA facilities, are nonresidential programs that provide case management, counseling, medical care and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week. The statute requires these day treatment programs, also known as partial hospitalization, to be included in the rule. Residential treatment programs are therapeutic programs for alcohol and drug dependent persons. They include therapeutic communities and transitional facilities.

The rule also requires coverage for intensive outpatient programs for the treatment of psychoactive substance use disorders provided by specialists in addiction medicine according to the patient placement criteria of the American society of addiction medicine.

Insurers must provide coverage for mental health day treatment or day hospital programs for adults and mental health services for children and adolescents offered by day treatment programs certified by DHSS. Coverage must also be available for the mental health services provided in community support programs offered by county departments of community programs throughout the state. These programs offer a variety of services to persons

with chronic mental illnesses which by history or prognosis require repeated acute treatment or prolonged periods of institutional care.

An insurer may meet the coverage requirements by covering substantially similar services and programs in another state, if the provider is in compliance with that state's requirements.

Each insurer must include in its policy form the types of transitional treatment programs which are covered (those specified in the rule) and a description of the method used to evaluate transitional treatment programs or services to determine medical necessity and eligibility for coverage under the policy.

The mandate to cover these services applies to policies issued and renewed on and after November 1, 1992. The commissioner is promulgating an emergency rule at the same time this proposed rule is submitted for legislative review so the rule will be in effect before the mandate applies.

The commissioner intends to continue to consult with the department of health and social services staff as they develop and revise certification procedures for mental health and AODA programs and to revise this rule as necessary to expand covered services as new programs which meet the definition of transitional treatment arrangements are certified.

SECTION 1. Ins 3.37 is created to read:

Ins 3.37 TRANSITIONAL TREATMENT ARRANGEMENTS. (1) PURPOSE. This section implements s. 632.89 (4), Stats.

(2) APPLICABILITY. This section applies to group and blanket disability insurance policies issued or renewed on and after November 1, 1992, that provide coverage for inpatient hospital services or outpatient services, as defined in s. 632.89 (1) (d) or (e), Stats.

(3) COVERED SERVICES. A policy subject to this section shall provide at least the amount of coverage required under s. 632.89 (2) (dm) 2, Stats., for all of the following:

(a) Mental health services for adults in a day treatment program offered by a provider certified by the department of health and social services under s. HSS 61.75.

(b) Mental health services for children and adolescents in a day treatment program offered by a provider certified by the department of health and social services under s. HSS 61.81.

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

(d) Residential treatment programs for alcohol or drug dependent persons or both certified by the department of health and social services under s. HSS 61.60.

(e) Services for alcoholism and other drug problems provided in a day treatment program certified by the department of health and social services under s. HSS 61.61.

(f) Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American society of addiction medicine.

(4) OUT-OF-STATE SERVICES AND PROGRAMS. An insurer may comply with sub. (3) (a) to (e) by providing coverage for services and programs that are substantially similar to those specified in sub. (3) (a) to (e), if the provider is in compliance with similar requirements of the state in which the provider is located.

(5) POLICY FORM REQUIREMENTS. An insurer 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. (3).

(b) The method the insurer 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 2. EFFECTIVE DATE. This rule will take effect on the first day of the first month after publication, as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this 11th day of January 1993.

John W. Torgerson
Deputy Commissioner of Insurance