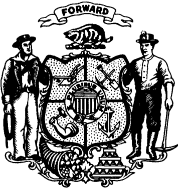

State of Wisconsin
1997 - 1998 LEGISLATURE

LRB–0446/1
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1997 ASSEMBLY BILL 652

December 11, 1997 – Introduced by Representatives URBAN, LADWIG, JOHNSRUD, WASSERMAN, BOCK, LORGE, VRAKAS, ROBSON, LAZICH, BRANDEMUEHL, OWENS, MUSSER, HASENOHRL, GUNDERSON, BAUMGART, PORTER, POWERS, SYKORA, J. LEHMAN, GOETSCH and BALDWIN, cosponsored by Senators WELCH, ROSENZWEIG, C. POTTER, ROESSLER, WIRCH, DARLING and A. LASEE. Referred to Committee on Health.

1 AN ACT ***to amend*** 40.51 (8c), 40.51 (8c), 40.51 (8r), 40.51 (8r), 185.981 (4t),
2 185.981 (4t), 185.981 (4t), 185.983 (1) (intro.), 185.983 (1) (intro.), 185.983 (1)
3 (intro.), 609.15 (1) (a), 609.20 (2) and 609.20 (4); and ***to create*** 40.51 (8c), 40.51
4 (8r), 628.42, 632.85, 632.855 and 632.865 of the statutes; **relating to:**
5 point–of–service coverage options, requirements for and certification of health
6 care plans and utilization review programs, prohibiting certain employment
7 terminations, prohibiting requiring prior authorization for emergency services
8 and granting rule–making authority.

Analysis by the Legislative Reference Bureau

Health care plan requirements

This bill establishes certain requirements for health care plans, which are defined as insurance contracts providing coverage of health care expenses. Under the bill, a health care plan must provide written information to prospective enrollees about the terms and conditions under the plan. Included must be such information as coverage provisions; premiums, deductibles and coinsurance requirements; any required prior authorization; any financial incentives for providers to limit health care services; enrollee satisfaction statistics; loss ratios; and a description of the plan's grievance and appeal procedures. In addition to providing the written information, a health care plan must:

1. Establish standards for enrollee access to specified types of providers and health care services.

2. Provide coverage for all drugs and devices that are approved by the federal food and drug administration and allow an enrollee's attending physician to determine the appropriate drug for the enrollee's needs.

3. Develop a written policy on continuity of care and provide at least 30 days' notice to an enrollee if a provider who has been treating the enrollee terminates participation with the health care plan.

4. Establish a physician advisory committee for various specified purposes, including providing advice on the plan's medical policies and conducting peer review activities.

5. Establish procedures for fairly and systematically soliciting and acting on physician applications for participation in the plan and make the criteria for physician selection for participation in the plan available to physician applicants and the public.

6. Provide a physician with a written statement of reasons and an opportunity for a hearing prior to any restriction or termination of the physician's participation in the plan.

Under the bill, a health care plan must limit physician participation in the plan to 2–year periods. A participating physician must submit an application to continue participation in the plan and the plan must use the same criteria for continued participation that it used for initial participation.

A health care plan may not prohibit or restrict a participating provider from disclosing to an enrollee any health care information that the provider determines is medically appropriate regarding the nature of, alternatives to or risks associated with treatment being provided to the enrollee. The bill prohibits a health care plan from offering payment to a physician as an inducement to reduce or limit medically appropriate services.

The bill requires a health care plan to respond to a request for nonemergency services within 2 business days after the request is received. Emergency care must be provided without prior authorization.

The bill requires a health care plan to establish a utilization review program. Under the utilization review program, a health care plan must appoint a physician as its medical director, to be responsible for all clinical decisions made under the plan. The health care plan must contract with a reviewer to make recommendations on coverage or payment for services and on medical appropriateness of services. If services or coverage for services is denied on the basis that the treatment is or was not medically appropriate, the health care plan must provide the enrollee and provider with a statement of reasons for the denial and with instructions for appealing the decision. The plan must provide for review of the denial, first by the medical director, next by the physician advisory committee and finally by a physician who is not participating in the plan and who is determined by the plan's physician advisory committee to be qualified to evaluate the treatment that was the subject of the denial.

Under the bill, a health care plan may apply to the commissioner of insurance for certification that the health care plan is in compliance with the requirements established in the bill. The commissioner must appoint a task force made up of equal numbers of physicians, other providers, benefit managers, consumers of health care services and representatives of insurers to advise the commissioner on developing standards for the certification of health care plans.

Point–of–service coverage option

The bill requires any health care plan that controls utilization of health care services or that requires its enrollees to obtain health care services from providers who are members of the plan's provider network to offer all of its enrollees a coverage option under which an enrollee has access to and coverage of health care services that are provided by one or more providers who are not part of the plan's provider network. A health care plan must offer this point–of–service coverage option for a one–month period at least annually and may charge an additional premium for the coverage option.

Retaliatory employment termination and emergency services

The bill prohibits a health care plan from terminating an employment or contractual relationship with, or otherwise penalizing, a physician or other provider on the basis that the provider appealed a payer's decision to deny payment for a service or protested a decision, policy or practice that the provider reasonably believed impaired his or her ability to provide medically appropriate health care. The bill prohibits a health care plan from requiring prior authorization for the provision or coverage of health care services or items that are provided in a hospital emergency facility for the treatment of an emergency medical condition. An emergency medical condition is defined as a medical condition that has a recent onset and symptoms of such severity that a prudent layperson could reasonably conclude that lack of immediate medical attention will likely result in serious consequences to the person's health, bodily functions or body parts.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

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

1 **SECTION 1.** 40.51 (8c) of the statutes is created to read:

2 40.51 **(8c)** Every health care coverage plan, except for an uninsured health care
3 coverage plan, offered by the state under sub. (6) shall comply with ss. 632.855 and
4 632.865.

5 **SECTION 2.** 40.51 (8c) of the statutes, as created by 1997 Wisconsin Act .... (this
6 act), section 1, is amended to read:

1 40.51 **(8c)** Every health care coverage plan, except for an uninsured health care
2 coverage plan, offered by the state under sub. (6) shall comply with ss. 632.85,
3 632.855 and 632.865.

4 **SECTION 3.** 40.51 (8c) of the statutes, as affected by 1997 Wisconsin Act .... (this
5 act), sections 1 and 2, is amended to read:

6 40.51 **(8c)** Every health care coverage plan, except for an uninsured health care
7 coverage plan, offered by the state under sub. (6) shall comply with ss. 628.42 (1) to
8 (3), 632.85, 632.855 and 632.865.

9 **SECTION 4.** 40.51 (8r) of the statutes is created to read:

10 40.51 **(8r)** Every health care coverage plan, except for an uninsured health care
11 coverage plan, offered by the group insurance board under sub. (7) shall comply with
12 ss. 632.855 and 632.865.

13 **SECTION 5.** 40.51 (8r) of the statutes, as created by 1997 Wisconsin Act ... (this
14 act), section 4, is amended to read:

15 40.51 **(8r)** Every health care coverage plan, except for an uninsured health care
16 coverage plan, offered by the group insurance board under sub. (7) shall comply with
17 ss. 632.85, 632.855 and 632.865.

18 **SECTION 6.** 40.51 (8r) of the statutes, as affected by 1997 Wisconsin Act ... (this
19 act), sections 4 and 5, is amended to read:

20 40.51 **(8r)** Every health care coverage plan, except for an uninsured health care
21 coverage plan, offered by the group insurance board under sub. (7) shall comply with
22 ss. 628.42 (1) to (3), 632.85, 632.855 and 632.865.

23 **SECTION 7.** 185.981 (4t) of the statutes, as affected by 1997 Wisconsin Act 27,
24 section 3133m, is amended to read:

1 185.981 **(4t)** A sickness care plan operated by a cooperative association is
2 subject to ss. 252.14, 631.89, 632.72 (2), 632.745 to 632.749, 632.855, 632.865, 632.87
3 (2m), (3), (4) and (5), 632.895 (10) to (13) and 632.897 (10) and chs. 149 and 155.

4 **SECTION 8.** 185.981 (4t) of the statutes, as affected by 1997 Wisconsin Act 27,
5 section 3133m, and 1997 Wisconsin Act .... (this act), section 7, is amended to read:

6 185.981 **(4t)** A sickness care plan operated by a cooperative association is
7 subject to ss. 252.14, 631.89, 632.72 (2), 632.745 to 632.749, 632.85, 632.855, 632.865,
8 632.87 (2m), (3), (4) and (5), 632.895 (10) to (13) and 632.897 (10) and chs. 149 and
9 155.

10 **SECTION 9.** 185.981 (4t) of the statutes, as affected by 1997 Wisconsin Act 27,
11 section 3133m, and 1997 Wisconsin Act .... (this act), sections 7 and 8, is amended to
12 read:

13 185.981 **(4t)** A sickness care plan operated by a cooperative association is
14 subject to ss. 252.14, 628.42 (1) to (3), 631.89, 632.72 (2), 632.745 to 632.749, 632.85,
15 632.855, 632.865, 632.87 (2m), (3), (4) and (5), 632.895 (10) to (13) and 632.897 (10)
16 and chs. 149 and 155.

17 **SECTION 10.** 185.983 (1) (intro.) of the statutes, as affected by 1997 Wisconsin
18 Act 27, section 3134m, is amended to read:

19 185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be
20 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
21 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.89, 631.93, 632.72
22 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.855, 632.865, 632.87 (2m), (3),
23 (4) and (5), 632.895 (5) and (9) to (13), 632.896 and 632.897 (10) and chs. 609, 630,
24 635, 645 and 646, but the sponsoring association shall:

SECTION 11. 185.983 (1) (intro.) of the statutes, as affected by 1997 Wisconsin Act 27, section 3134m, and 1997 Wisconsin Act .... (this act), section 10, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.89, 631.93, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.855, 632.865, 632.87 (2m), (3), (4) and (5), 632.895 (5) and (9) to (13), 632.896 and 632.897 (10) and chs. 609, 630, 635, 645 and 646, but the sponsoring association shall:

SECTION 12. 185.983 (1) (intro.) of the statutes, as affected by 1997 Wisconsin Act 27, section 3134m, and 1997 Wisconsin Act ... (this act), sections 10 and 11, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 628.42 (1) to (3), 631.89, 631.93, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.855, 632.865, 632.87 (2m), (3), (4) and (5), 632.895 (5) and (9) to (13), 632.896 and 632.897 (10) and chs. 609, 630, 635, 645 and 646, but the sponsoring association shall:

SECTION 13. 609.15 (1) (a) of the statutes is amended to read:

609.15 **(1)** (a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. (2) and s. 628.42 (3) (a) 5. and 6. for the resolution of enrolled participants' grievances with the health care plan.

SECTION 14. 609.20 (2) of the statutes is amended to read:

1 609.20 **(2)** To ensure that the continuity of patient care for enrolled participants
2 is not disrupted. The rules promulgated under this subsection shall be consistent
3 with s. 628.42 (2) (a) 5.

4 **SECTION 15.** 609.20 (4) of the statutes is amended to read:

5 609.20 **(4)** To ensure that employes offered a preferred provider plan that
6 provides comprehensive services under s. 609.10 (1) (a) are given adequate notice of
7 the opportunity to enroll and complete and understandable information under s.
8 609.10 (1) (c) concerning the differences between the preferred provider plan and the
9 standard plan, including differences between providers available and differences
10 resulting from special limitations or requirements imposed by an institutional
11 provider because of its affiliation with a religious organization. The rules
12 promulgated under this subsection shall be consistent with s. 628.42 (2) (a) 1.

13 **SECTION 16.** 628.42 of the statutes is created to read:

14 **628.42 Requirements for and certification of health care plans and**
15 **utilization review programs. (1)** DEFINITIONS. In this section:

16 (a) "Enrollee" means a person who is entitled to receive health care services
17 under an individual or group health care plan.

18 (b) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

19 (c) "Participating" means, with respect to a physician or other provider, under
20 contract with a health care plan to provide health care services, items or supplies to
21 enrollees of the health care plan.

22 (d) "Physician" has the meaning given in s. 448.01 (5).

23 (e) "Provider" means a hospital, as defined in s. 50.33 (2), or any person who
24 is licensed, registered, permitted or certified by the department of health and family

1 services or the department of regulation and licensing to provide health care
2 services, items or supplies in this state.

3 **(2)** REQUIREMENTS FOR HEALTH CARE PLANS. (a) A health care plan shall do all
4 of the following:

5 1. Provide written information to prospective enrollees about the terms and
6 conditions under the health care plan. The information must be presented in a
7 standardized format to enable prospective enrollees to compare the attributes of
8 different health care plans. The information must be presented in readable, easily
9 understood language and must include all of the following:

10 a. Coverage provisions, benefits included and service or provider exclusions or
11 limitations.

12 b. Premiums, deductibles, coinsurance requirements and any other financial
13 requirements having an effect, with respect to the cost of coverage, on an enrollee or
14 other person making payments on behalf of an enrollee.

15 c. Any prior authorization or other review requirements and any procedures
16 or other services for which an enrollee may be denied coverage.

17 d. Any penalties imposed against providers or utilization review entities for
18 providing or approving too many health care services.

19 e. Any financial arrangements or other contractual agreements with providers
20 or utilization review entities, including financial incentives or rewards for the
21 limitation, restriction or high utilization of health care services or pharmaceuticals.

22 f. Any incentives provided to providers or utilization review entities for
23 restricting referral or treatment options, including capitation, discounted
24 fee–for–service, arrangements with pharmaceutical companies and salary
25 arrangements.

1 g. An explanation of how determinations are made, under the health care plan,
2 of whether a service or item is covered, including services and items developed under
3 new and emerging technology.

4 h. Restrictions limiting coverage to services provided by certain specified
5 providers or facilities and information on enrollee responsibility for payment for
6 services not covered or unavailable under the health care plan.

7 i. The health care plan's loss ratios, calculated according to a standard
8 computation and reporting methodology, and a plain language explanation of what
9 a loss ratio is.

10 j. Enrollee satisfaction statistics, including reenrollment percentage and
11 stated reasons for not reenrolling.

12 k. Provider satisfaction statistics, including continued participation
13 application percentage and stated reasons for not applying for continued
14 participation.

15 L. Coverage, and definition, of experimental procedures.

16 m. Enrollee access to participation in approved clinical trials.

17 n. Enrollee access to medical specialists and any related referral policies or
18 procedures.

19 o. Coverage, and definition, of emergency services.

20 p. Any special provisions or limitations applicable to mental health services.

21 q. Pharmaceuticals approved for use by the participating physicians.

22 r. A description of the grievance and appeal procedures available under the
23 health care plan and the percentage of appeals in which the initial denial of a claim
24 has been reversed in each of the preceding 3 years.

1 2. To ensure that its enrollees have reasonable access to providers within the
2 geographic area covered by the plan and that all covered health care services are
3 provided in a timely manner, establish standards for access to primary care
4 physicians, specialty care, routine, urgent and emergency care and the necessary
5 services of other providers.

6 3. Provide coverage to enrollees for all drugs and devices that are approved for
7 use by the federal food and drug administration; allow an enrollee's attending
8 physician to determine the appropriate drug that meets the enrollee's needs; and
9 provide information to, and otherwise educate, enrollees, participating physicians
10 and pharmacists about appropriate prescription drug use.

11 4. To ensure appropriate patterns of pharmaceuticals use, establish drug
12 utilization review procedures for managing the cost of pharmaceuticals.

13 5. Develop a policy, and reduce it to writing, to provide for continuity of care for
14 its enrollees. The policy shall require at least 30 days' notice of a provider's
15 termination of participation in the health care plan to any enrollee who selected the
16 provider or who is receiving a course of treatment that is being provided by the
17 provider. The written policy shall address how the health care plan intends to
18 facilitate the continuity of care for new enrollees receiving services during a current
19 episode of care for an acute condition from a nonparticipating provider and for
20 current enrollees when the participation of a provider selected by an enrollee, or from
21 whom an enrollee is receiving a course of treatment, terminates. The written policy
22 shall describe the procedures to be used by an enrollee to request a continuation of
23 services. With respect to determining whether to continue services, the policy shall
24 give reasonable consideration to the clinical effect that a change of provider may
25 have on an enrollee's treatment for an acute condition. The health care plan may

require any nonparticipating provider whose services are covered under its continuity–of–care policy to agree to meet the same contractual conditions and requirements that participating providers must meet. The health care plan is not required, under its continuity–of–care policy, to cover services or provide benefits not otherwise covered or provided under the terms of the health care plan or to provide continuity of care to an enrollee who is offered a point–of–service option, as defined in s. 632.85 (1) (c), or to a new enrollee who had the option to continue with his or her previous health care plan but who chose to change plans voluntarily.

6. To ensure that proper payment is made for covered services, meet all applicable state and federal statutory and regulatory requirements related to financial reserves.

7. Establish a physician advisory committee to provide advice regarding the plan's medical policies, including the range of services to be provided and the use of new technologies and procedures for providing care; to provide advice regarding the plan's utilization review program, if any; to conduct peer review activities; to hear appeals of decisions of the plan's medical director under sub. (3) (a) 5. a. and 6. a.; to make recommendations to the governing body on initial and ongoing physician participation; and to serve as liaison between the governing body and participating physicians regarding matters of mutual interest and concern. The physician advisory committee must consist of at least 5 members. All members must be physicians participating in the health care plan. Election of committee members, leadership of the committee and the governance of the committee must be determined in accordance with rules adopted by the committee, except that any participating physician must be eligible for election to the committee and the initial membership and leadership of the committee, for a period not exceeding 90 days,

shall be determined by the governing body of the health care plan. The physician advisory committee must have reasonable discretion to appoint committees and in discharging its responsibilities, including the authority to adopt rules, policies and procedures, which may be subject to approval by the health care plan's governing body.

8. Establish, in consultation with the plan's physician advisory committee, procedures for fairly and systematically, consistent with the plan's business needs, capacity and objectives, soliciting and acting upon physician applications for participation in the plan. Any physician shall be allowed to apply for participation in the plan. The procedures for soliciting and acting upon physician applications shall be reviewed annually and must include all of the following:

a. Making available in writing to applicants and to the public the objective criteria used by the plan in selecting physicians for participation in the plan, including such physician criteria as education, training, background, experience, professional disposition, demonstrated competence, demonstrated quality, membership or clinical privileges at a particular hospital and membership in a particular medical group, and including such plan criteria as professional liability insurance requirements and the number of physicians in a given specialty that are needed by the plan.

b. The review of each application by physicians representing the applicant's area of medical specialty.

c. Procedures to ensure that, whenever a physician's graduate medical education is a factor in selection for participation, training programs accredited by the Accrediting Council on Graduate Medical Education or the American Osteopathic Association are given equal recognition.

1 d. Procedures to ensure that, whenever the economics or capacity of a
2 physician's practice is a criterion used in selection for participation, that criterion is
3 documented and made available to physician applicants, physicians participating in
4 the plan and the plan's enrollees. Any such economic or capacity criterion used in
5 selection for participation must be adjusted to reflect a physician's patient case mix,
6 including severity of illnesses and ages of individuals who are patients of the
7 physician, and any other features of the physician's practice that may account for
8 costs or services utilization that is higher or lower than expected.

9 e. Procedures to ensure that the health care plan does not discriminate against
10 high–risk or vulnerable individuals or individuals with expensive–to–treat,
11 long–term or chronic medical conditions by excluding from participation physicians
12 with practices that include a substantial number of such individuals.

13 f. Procedures to ensure that the health care plan does not select physicians for
14 participation on the basis of sex, race, creed, national origin or any other factor
15 prohibited by law.

16 9. Establish, in consultation with the plan's physician advisory committee,
17 procedures to ensure fairness in processing physician applications for participation
18 in the plan and in making decisions regarding the status of a physician's
19 participation in the plan. The procedures must include all of the following:

20 a. Reasonably prompt consideration of a participation application or renewal
21 and reasonably prompt notification to the physician of a decision regarding initial
22 or renewed participation. A health care plan is not required to act on an incomplete
23 application, but must inform an applicant who submits an incomplete application of
24 the data that is missing and must afford the applicant a reasonable opportunity to
25 provide the missing data.

1 b. Providing a physician with a written statement of reasons and an
2 opportunity to respond, in writing or orally at a hearing, before the governing body
3 of the plan makes a final decision to deny a participation application or renewal; to
4 suspend or restrict participation in the plan for longer than 30 days; or to terminate
5 or permanently restrict participation in the plan. If the action under consideration
6 by the governing body is of a type that must be reported under state or federal law
7 to the National Practitioner Data Bank or to the medical examining board, the
8 physician's procedural rights must meet, at a minimum, the standards of fairness
9 required under the federal Health Care Quality Improvement Act of 1986, 42 USC
10 11101 to 11152.

11 c. Providing a physician with a written statement of reasons and an
12 opportunity to respond, in writing or orally at a hearing, before the governing body
13 of the plan makes a final decision to terminate, deny or restrict a physician's
14 participation in the plan on the basis of utilization of services or economic criteria.
15 The reasons stated must include consideration and recognition of the physician's
16 patient case mix, including severity of illnesses and ages of enrollees who are
17 patients of the physician, and any other features of the physician's practice that may
18 account for costs that are higher or lower than expected. In addition to an
19 opportunity to respond, a physician must have an opportunity to enter into and
20 complete a corrective action plan, except in cases in which there is imminent danger
21 of harm to patient health or action by the medical examining board or another
22 governmental entity that effectively impairs the physician's ability to practice
23 medicine in this state.

24 d. Providing a physician who is subject to summary suspension or restriction
25 of participation in the plan based on a determination of imminent danger to the

1 health of enrollees or other individuals with the opportunity for a hearing within 14
2 days after the summary suspension or restriction is imposed. The summary
3 suspension or restriction may be continued, modified or reversed at the hearing by
4 the governing body. A summary suspension or restriction of participation may be
5 imposed only by plan officials, including at least one member of the physician
6 advisory committee, who are expressly authorized to do so under the terms of the
7 plan.

8 10. Limit a physician's participation in the health care plan to 2–year periods.
9 The health care plan shall require a physician who wishes to continue to participate
10 in the health care plan to submit an application for continued participation at the end
11 of each 2–year period. Upon submission of an application for continued
12 participation, the health care plan shall evaluate the participating physician
13 submitting the application according to the same criteria used at the time that
14 application for initial participation was approved to determine whether the
15 physician continues to qualify for participation in the plan.

16 11. Establish procedures to ensure compliance with all applicable state and
17 federal laws designed to protect the confidentiality of provider and enrollee records.

18 (b) In addition to satisfying the requirements under par. (a), a health care plan
19 may not prohibit or restrict a participating provider from disclosing to an enrollee
20 any health care information that the provider determines is medically appropriate
21 regarding the nature of, risks associated with, and alternatives to, proposed
22 treatment or treatment being provided to the enrollee; the availability of alternative
23 therapies, consultation or tests; the decision of the health care plan to authorize or
24 deny coverage for services; or the process that the health care plan uses or proposes
25 to use to authorize or deny benefits or coverage for health care services.

1 (c) A health care plan may not offer payment directly or indirectly to a physician
2 or physician group as an inducement to reduce or limit medically appropriate
3 services or pharmaceuticals or to promote high utilization of services or
4 pharmaceuticals.

5 (d) A health care plan shall establish and operate a utilization review program.

6 (e) A health care plan may apply to the commissioner for certification under
7 sub. (4) that the health care plan satisfies the requirements under this subsection.

8 **(3)** REQUIREMENTS FOR UTILIZATION REVIEW PROGRAMS. (a) A health care plan,
9 with respect to its utilization review program, shall do all of the following:

10 1. Appoint a medical director, who is a physician, to be responsible for all
11 clinical decisions that are based on recommendations made by the health care plan's
12 reviewer under subd. 4., to hear appeals of decisions of the health care plan's
13 reviewer under subds. 5. a. and 6. a. and to ensure that the medical review and other
14 utilization practices employed under the plan's utilization review program comply
15 with the requirements under this subsection.

16 2. Develop, based on sound scientific principles and in cooperation with
17 practicing physicians and other affected providers, the screening criteria, weighing
18 elements and computer algorithms to be used in the health care plan's utilization
19 review program.

20 3. Upon request, release to enrollees, providers and health care facilities the
21 screening criteria, weighting elements and computer algorithms used in the health
22 care plan's utilization review process and the method by which each was developed.
23 The health care plan may require any enrollee, provider or health care facility
24 receiving information under this subdivision to agree to keep the information
25 confidential.

1 4. Contract with a reviewer to make recommendations on coverage for services,
2 payment for services and whether services should be provided on the basis of medical
3 appropriateness. The reviewer must be a physician whose area of medical specialty
4 is recognized by the American Board of Medical Specialties or the American
5 Osteopathic Association and who is determined by the health care plan's physician
6 advisory committee to be qualified to evaluate issues related to coverage and
7 services. The reviewer's compensation may not be directly affected by the decisions
8 or recommendations that he or she makes.

9 5. a. Provide to an enrollee and provider seeking prior authorization for
10 treatment that is denied on the basis that the treatment is not medically appropriate
11 a written statement of the reasons for the denial. The statement of reasons must be
12 documented in the case record and must include a general description of the reason
13 that prior authorization for the treatment was denied, an explanation of the
14 enrollee's and physician's appeal rights and instructions for the enrollee and
15 physician to appeal to the plan's medical director and thereafter to the plan's
16 physician advisory committee.

17 b. Provide for final review of a denial of prior authorization for treatment on
18 the basis that the treatment was determined to be not medically appropriate after
19 appeals have been heard by both the plan's medical director and the plan's physician
20 advisory committee. The review must be conducted by a person who is licensed to
21 practice medicine in the jurisdiction in which the claim arose, who is not
22 participating in or under contract with the health care plan, whose area of medical
23 specialty is recognized by the American Board of Medical Specialties or the American
24 Osteopathic Association and who is determined by the health care plan's physician
25 advisory committee to be qualified to evaluate the proposed treatment under review.

1 The determination on review under this subd. 5. b. shall be made in accordance with
2 the relevant laws and regulations of the jurisdiction in which the claim arose.

3 6. a. Provide to an enrollee and provider submitting a claim that is denied on
4 the basis that the treatment provided was not medically appropriate a written
5 statement of the reasons for denying the claim. The statement of reasons must be
6 documented in the case record and must include a general description of the reason
7 that coverage for the treatment was denied, an explanation of the enrollee's and
8 physician's appeal rights and instructions for the enrollee and physician to appeal
9 to the plan's medical director and thereafter to the plan's physician advisory
10 committee.

11 b. Provide for final review of a denial of a claim on the basis that the treatment
12 provided was determined to be not medically appropriate after appeals have been
13 heard by both the plan's medical director and the plan's physician advisory
14 committee. The review must be conducted by a person who is licensed to practice
15 medicine in the jurisdiction in which the claim arose, who is not participating in or
16 under contract with the health care plan, whose area of medical specialty is
17 recognized by the American Board of Medical Specialties or the American
18 Osteopathic Association and who is determined by the health care plan's physician
19 advisory committee to be qualified to evaluate the treatment under review. The
20 determination on review under this subd. 6. b. shall be made in accordance with the
21 relevant laws and regulations of the jurisdiction in which the claim arose.

22 7. Provide to an enrollee or a physician participating in the plan, upon request,
23 the names and credentials of all individuals conducting medical appropriateness
24 review under the plan's utilization review program.

8. Provide emergency care, including medical screening exams and stabilizing treatment, to enrollees without prior authorization.

9. Respond to a request from an enrollee or physician for prior authorization for nonemergency medical services within 2 business days after receiving the request.

10. Make available qualified personnel to respond by telephone to any inquiry about medical appropriateness, including determination of length of stay, on the same day that the inquiry is made, except that a health care plan must respond to a request for an extension of an approved length of stay within 3 hours of the request.

11. Ensure that each enrollee, upon enrollment, signs a written medical information release consent for use whenever prior authorization is a condition for the coverage of a service.

12. Treat prior approval for a service or item as approval for all purposes such that the same service or item provided again during the same course of treatment must thereafter be covered without further approval, unless the approval was obtained fraudulently or incorrect information was provided at the time that the approval was obtained.

13. Establish procedures to ensure compliance with all applicable state and federal laws designed to protect the confidentiality of provider and enrollee records.

(b) A health care plan may apply to the commissioner for certification under sub. (4) that, with respect to its utilization review program, the health care plan satisfies the requirements under this subsection.

(4) CERTIFICATION, RECERTIFICATION AND TERMINATION OF CERTIFICATION. (a) Under procedures and according to standards established by the commissioner, the commissioner shall do all of the following:

1 1. Certify health care plans that satisfy the requirements under sub. (2).
2 2. Certify utilization review programs that satisfy the requirements under sub.
3 (3).
4 3. Consider and act upon applications for certification in a timely manner.
5 4. Periodically review health care plans and utilization review programs that
6 have been certified by the commissioner.
7 5. Every 2 years, recertify a health care plan that has been certified and that
8 continues to satisfy the requirements under sub. (2).
9 6. Every 2 years, recertify a utilization review program that has been certified
10 and that continues to satisfy the requirements under sub. (3).
11 7. Terminate the certification of a health care plan or utilization review
12 program that has been certified and that no longer satisfies the requirements under
13 sub. (2) or (3). If the commissioner determines that a health care plan or utilization
14 review program no longer satisfies the requirements under sub. (2) or (3), the
15 commissioner shall provide the health care plan or utilization review program with
16 notice and an opportunity for a hearing before terminating a certification.
17 (b) The commissioner shall appoint a task force to advise the commissioner on
18 developing standards for certification of satisfaction of the requirements under subs.
19 (2) and (3). The task force shall consist of equal numbers of physicians, other
20 providers, benefit managers, consumers of health care services and representatives
21 of insurers.
22 **(5)** DEVELOPMENT AND REVISION OF CERTIFICATION STANDARDS; RULES. (a) In
23 developing the standards for certification under sub. (4), the commissioner shall
24 review standards in use by the National Committee for Quality Assurance and the
25 Joint Commission for the Accreditation of Health Care Organizations and shall

1 recognize the differences in organizational structure and operation of the various
2 types of health care plans.

3 (b) The commissioner shall periodically review the certification standards
4 established under sub. (4) and may revise the standards after consulting with the
5 task force appointed under sub. (4) (b).

6 (c) The commissioner shall by rule specify the standardized format that health
7 care plans must use for providing the information under sub. (2) (a) 1.

8 **SECTION 17.** 632.85 of the statutes is created to read:

9 **632.85 Point–of–service coverage options. (1)** DEFINITIONS. In this
10 section:

11 (a) "Enrollee" means an individual who is entitled to receive health care
12 services under an individual or group health care plan.

13 (b) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

14 (c) "Point–of–service option" means a coverage option of a health care plan that
15 provides to enrollees of the health care plan additional coverage or access to and
16 coverage of health care services, items or supplies provided by one or more providers
17 who are not members of the provider network of the enrollee's health care plan.

18 (d) "Provider" means a hospital, as defined in s. 50.33 (2), or any person who
19 is licensed, registered, permitted or certified by the department of health and family
20 services or the department of regulation and licensing to provide health care
21 services, items or supplies in this state.

22 (e) "Provider network" means those providers who are under contract with a
23 health care plan to provide health care services, items or supplies to enrollees of or
24 insureds under the health care plan.

1 **(2)** REQUIREMENT TO OFFER COVERAGE OPTION. A health care plan that requires
2 its enrollees to obtain health care services, items or supplies from providers who are
3 members of the plan's provider network or that controls utilization of health care
4 services shall offer to all of its enrollees, for a one–month period at least once
5 annually, the opportunity to select a point–of–service option. In addition, the health
6 care plan shall offer this opportunity to every enrollee who obtains coverage under
7 the health care plan on or after the effective date of this subsection .... [revisor inserts
8 date], when the enrollee obtains coverage under the health care plan.

9 **(3)** PREMIUMS. A health care plan may charge an enrollee who selects a
10 point–of–service option an additional premium for the coverage. The additional
11 premium may not exceed the actuarial value of the enrollee's coverage under the
12 point–of–service option.

13 **(4)** COINSURANCE. A health care plan may require the payment of coinsurance
14 for health care services, items and supplies covered by the point–of–service option.
15 Such coinsurance may not exceed 20% of the cost of a service, item or supply.

16 **SECTION 18.** 632.855 of the statutes is created to read:

17 **632.855 Prohibition against retaliatory employment termination. (1)**
18 In this section:

19 (a) "Physician" has the meaning given in s. 448.01 (5).

20 (b) "Provider" means a hospital, as defined in s. 50.33 (2), or any person who
21 is licensed, registered, permitted or certified by the department of health and family
22 services or the department of regulation and licensing to provide health care
23 services, items or supplies in this state.

24 **(2)** No health care plan, as defined in s. 628.36 (2) (a) 1., may terminate an
25 employment or contractual relationship with a physician or other provider, or

1 otherwise penalize a physician or other provider, principally on the basis of any of
2 the following:
3 (a) That the physician or other provider, under an established grievance or
4 appeal procedure, appealed a payer's decision to deny payment for a service.
5 (b) That the physician or other provider protested a decision, policy or practice
6 that the physician or other provider reasonably believed impaired his or her ability
7 to provide medically appropriate health care to his or her patients.
8 **SECTION 19.** 632.865 of the statutes is created to read:
9 **632.865 No prior authorization for emergency services. (1)** In this
10 section, "emergency medical condition" means a medical condition of a person that
11 has a recent onset and that manifests itself by symptoms of sufficient severity,
12 including severe pain, to lead a prudent layperson who possesses an average
13 knowledge of health and medicine to reasonably conclude that a lack of immediate
14 medical attention will likely result in any of the following:
15 (a) Serious jeopardy to the person's health.
16 (b) Serious impairment to the person's bodily functions.
17 (c) Serious dysfunction of one or more of the person's body organs or parts.
18 **(2)** A health care plan, as defined in s. 628.36 (2) (a) 1., may not require prior
19 authorization for the provision or coverage of health care items or services, including
20 a medical screening exam and stabilizing treatment, as defined in section 1867 of the
21 federal Social Security Act, that are provided in a hospital emergency facility for the
22 treatment of an emergency medical condition.
23 **SECTION 20. Nonstatutory provisions.**
24 (1) The commissioner of insurance shall submit in proposed form the rules
25 required under section 628.42 (5) (c) of the statutes, as created by this act, to the

1 legislative council staff under section 227.15 (1) of the statutes no later than the first
2 day of the 6th month beginning after the effective date of this subsection.

3 **SECTION 21. Initial applicability.**

4 (1) HEALTH CARE PLAN REQUIREMENTS. If a contract that is affected by section
5 628.42 of the statutes, as created by this act, that is in effect on the first day of the
6 13th month beginning after publication and that was not issued or renewed after the
7 effective date of this subsection contains terms or provisions that are inconsistent
8 with the requirements under section 628.42 of the statutes, as created by this act,
9 the treatment of sections 40.51 (8c) (by SECTION 3) and (8r) (by SECTION 6), 185.981
10 (4t) (by SECTION 9), 185.983 (1) (intro.) (by SECTION 12), 609.15 (1) (a), 609.20 (2) and
11 (4) and 628.42 of the statutes first applies to that contract upon renewal.

12 (2) POINT–OF–SERVICE COVERAGE OPTION. The treatment of sections 40.51 (8c) (by
13 SECTION 2) and (8r) (by SECTION 5), 185.981 (4t) (by SECTION 8), 185.983 (1) (intro.) (by
14 SECTION 11) and 632.85 of the statutes first applies to all of the following:

15 (a) Except as provided in paragraph (b), insurance policies, plans or certificates
16 that are issued or renewed on the effective date of this paragraph.

17 (b) Insurance policies, plans or certificates covering employes who are affected
18 by a collective bargaining agreement containing provisions inconsistent with this act
19 that are issued or renewed on the earlier of the following:

20 1. The day on which the collective bargaining agreement expires.

21 2. The day on which the collective bargaining agreement is extended, modified
22 or renewed.

23 (3) RETALIATORY EMPLOYMENT TERMINATION. If a contract in existence on the
24 effective date of this subsection between a health care plan, as defined in section
25 628.36 (2) (a) 1. of the statutes, and a physician, as defined in section 448.01 (5) of

1 the statutes, or a provider, as defined in section 632.855 (1) (b) of the statutes,
2 contains terms or provisions that are inconsistent with the prohibitions under
3 section 632.855 of the statutes, as created by this act, the treatment of sections 40.51
4 (8c) (by SECTION 1) (with respect to retaliatory employment termination) and (8r) (by
5 SECTION 4) (with respect to retaliatory employment termination), 185.981 (4t) (by
6 SECTION 7) (with respect to retaliatory employment termination), 185.983 (1) (intro.)
7 (by SECTION 10) (with respect to retaliatory employment termination) and 632.855
8 of the statutes first applies to that health care plan with respect to that physician or
9 provider upon renewal of the contract.

10 (4) EMERGENCY SERVICES. The treatment of sections 40.51 (8c) (by SECTION 1)
11 (with respect to emergency services) and (8r) (by SECTION 4) (with respect to
12 emergency services), 185.981 (4t) (by SECTION 7) (with respect to emergency
13 services), 185.983 (1) (intro.) (by SECTION 10) (with respect to emergency services)
14 and 632.865 of the statutes first applies to all of the following:

15 (a) Except as provided in paragraph (b), insurance policies, plans or certificates
16 that are issued or renewed on the effective date of this paragraph.

17 (b) Insurance policies, plans or certificates covering employes who are affected
18 by a collective bargaining agreement containing provisions inconsistent with this act
19 that are issued or renewed on the earlier of the following:

20 1. The day on which the collective bargaining agreement expires.

21 2. The day on which the collective bargaining agreement is extended, modified
22 or renewed.

23 **SECTION 22. Effective dates.** This act takes effect on January 1, 1998, or on
24 the day after publication, whichever is later, except as follows:

1 (1) POINT-OF-SERVICE COVERAGE OPTION. The treatment of sections 40.51 (8c) (by
2 SECTION 2) and (8r) (by SECTION 5), 185.981 (4t) (by SECTION 8), 185.983 (1) (intro.) (by
3 SECTION 11) and 632.85 of the statutes and SECTION 21 (2) of this act take effect on
4 the first day of the 9th month beginning after publication.

5 (2) HEALTH CARE PLAN REQUIREMENTS. The treatment of sections 40.51 (8c) (by
6 SECTION (3) and (8r) (by SECTION (6), 185.981 (4t) (by SECTION (9), 185.983 (1) (intro.)
7 (by SECTION (12), 609.15 (1) (a), 609.20 (2) and (4) and 628.42 (1), (2), (3), (4) (a) and
8 (5) (b) of the statutes takes effect on the first day of the 13th month beginning after
9 publication.

10 **(END)**