State of Wisconsin
1997 - 1998 LEGISLATURE

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1997 ASSEMBLY BILL 673

December 23, 1997 - Introduced by Representatives WASSERMAN, R. POTTER, LADWIG, URBAN, JOHNSRUD, BOCK, GUNDERSON, BLACK, BRANDEMUEHL, ROBSON, WARD, LINTON, KAUFERT, TRAVIS, SERATTI, BALDWIN, LORGE, BAUMGART, DOBYNS, HEBL, HAHN, J. LEHMAN, MUSSER, NOTESTEIN, OURADA, RYBA, OWENS, VANDER LOOP, HASENOHRL, CULLEN, R. YOUNG, PORTER and TURNER, cosponsored by Senators ROESSLER, WIRCH, ROSENZWEIG, C. POTTER, SCHULTZ, WINEKE, WELCH, CLAUSING, DRZEWIECKI, DARLING and PANZER. Referred to Committee on Health.

AN ACT ***to repeal*** 609.01 (1); ***to amend*** 51.20 (7) (am), 601.42 (1g) (d), 609.01 (2), 609.01 (3), 609.01 (4), 609.01 (7), 609.05 (1), 609.05 (2), 609.05 (3), 609.10 (1) (a), 609.15 (1) (intro.), 609.15 (1) (a), 609.15 (1) (b), 609.15 (2) (a), 609.15 (2) (b), 609.17, 609.20 (intro.), 609.20 (1), 609.20 (2), 609.20 (4), 609.65 (1) (intro.), 609.65 (1) (a), 609.65 (1) (b) (intro.), 609.65 (1) (b) 1., 609.65 (1) (b) 2., 609.65 (2), 609.65 (3), 609.655 (2), 609.655 (5) (a), 609.655 (5) (b), 609.70, 609.75, 609.80, 609.81, 609.91 (1) (intro.), 609.91 (1) (b) 2., 609.91 (1) (b) 3., 609.91 (1m), 609.91 (2), 609.91 (3), 609.91 (4) (intro.), 609.91 (4) (a), 609.91 (4) (b), 609.91 (4) (c), 609.91 (4) (cm), 609.91 (4) (d), 609.92 (5), 609.94 (1) (b), 645.69 (1), 645.69 (2), 646.31 (1) (d) 8. and 646.31 (1) (d) 9.; ***to repeal and recreate*** 40.51 (12), 609.01 (1d), 609.01 (5) and 609.01 (6); and ***to create*** 40.51 (13), 609.01 (1c), 609.01 (1p), 609.01 (3c), 609.01 (3m), 609.01 (3r), 609.01 (4m), 609.22, 609.24, 609.26,

609.28, 609.30, 609.32, 609.34, 609.36 and 609.38 of the statutes; **relating to:** requirements for managed care plans and granting rule–making authority.

Analysis by the Legislative Reference Bureau

Current law contains certain requirements that apply to health maintenance organizations, preferred provider plans and limited service health organizations (managed care plans). Those requirements address when an employer must offer a standard plan in addition to a managed care plan, coverage under a managed care plan for a child who is away at school, reporting disciplinary action taken against a participating provider and a grievance procedure. This bill provides for additional requirements which, in general, benefit enrollees under managed care plans and providers that provide health care services on behalf of those plans.

The bill requires a managed care plan to ensure that enrollees have adequate access to health care services by including a sufficient number and sufficient types of primary care providers throughout the service area of the plan. The plan must cover the services of nonparticipating specialist physicians for those enrollees who have medical conditions that cannot be adequately treated by participating providers. A managed care plan must provide enrollees with 24–hour telephone access for emergency care and authorization for care. A managed care plan must cover emergency care and may not require prior authorization for such care.

A managed care plan must permit an enrollee to choose a primary provider from a diverse list of participating providers. An enrollee with special medical needs must be able to select a specialist physician as a primary provider. A managed care plan must cover 2nd opinions from participating providers and must offer a point–of–service option under which an enrollee may obtain covered services from one or more nonparticipating providers of the enrollee's choice.

A managed care plan must provide coverage for any drug or device that is approved by the federal food and drug administration, as long as it is determined to be medically appropriate and necessary by the treating physician, regardless of whether the drug or device is being used for the purpose for which approved by the federal food and drug administration. The treating physician must be able to determine the drug therapy that is appropriate for the enrollee. A managed care plan must establish a drug utilization review program for the purpose of ensuring appropriate drug therapies for enrollees.

If a managed care plan limits coverage for experimental treatment, the plan must disclose who is authorized to make a determination on limiting coverage and the criteria used to determine whether a treatment, procedure, drug or device is experimental. Whenever coverage for experimental treatment is denied, the plan must provide the enrollee with a denial letter that advises the enrollee of who made the coverage decision, the reasons for the denial, alternative treatments that would be covered under the plan and the plan's grievance and appeal procedures.

A managed care plan must establish an internal quality assurance program, a peer review process and processes for selecting participating providers and

reevaluating those providers after initial acceptance into the plan. A managed care plan must appoint a physician as medical director to be responsible for the treatment policies, protocols, quality assurance activities and utilization management decisions of the plan.

A managed care plan must inform enrollees of any financial arrangement between the plan and a participating physician that operates as an incentive or bonus for restricting services. In addition, a managed care plan may not penalize or terminate the contract of a participating provider for discussing with an enrollee financial incentives under the plan. A managed care plan may not penalize or terminate the contract of a participating provider for making referrals to other participating providers or for discussing medically necessary or appropriate care with an enrollee.

Under current law, the commissioner of insurance is required to promulgate rules for preferred provider plans to ensure that enrollees are not forced to travel excessive distances to receive health care services and to ensure continuity of care for enrollees. The bill requires those rules to apply more broadly to all managed care plans.

For further information see the ***state and local*** 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:

SECTION 1. 40.51 (12) of the statutes is repealed and recreated to read:

40.51 **(12)** Every managed care plan, as defined in s. 609.01 (3c), that is offered by the state under sub. (6) shall comply with ch. 609.

SECTION 2. 40.51 (13) of the statutes is created to read:

40.51 **(13)** Every managed care plan, as defined in s. 609.01 (3c), that is offered by the group insurance board under sub. (7) shall comply with ch. 609.

SECTION 3. 51.20 (7) (am) of the statutes is amended to read:

51.20 **(7)** (am) A subject individual may not be examined, evaluated or treated for a nervous or mental disorder pursuant to a court order under this subsection unless the court first attempts to determine whether the person is an ~~enrolled participant~~ enrollee of a health maintenance organization, limited service health organization or preferred provider plan, as defined in s. 609.01 (4), and, if so, notifies

the organization or plan that the subject individual is in need of examination, evaluation or treatment for a nervous or mental disorder.

SECTION 4. 601.42 (1g) (d) of the statutes is amended to read:

601.42 **(1g)** (d) Statements, reports, answers to questionnaires or other information, or reports, audits or certification from a certified public accountant or an actuary approved by the commissioner, relating to the extent liabilities of a health maintenance organization insurer are or will be ~~covered liabilities, as defined in s. 609.01 (1)~~ liabilities for health care costs for which an enrollee or policyholder of the health maintenance organization insurer is not liable to any person under s. 609.91.

SECTION 5. 609.01 (1) of the statutes is repealed.

SECTION 6. 609.01 (1c) of the statutes is created to read:

609.01 **(1c)** "Emergency medical condition" means a medical condition of a person that has a sudden onset and that manifests itself by symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention might result in any of the following:

(a) Serious jeopardy to the person's health.

(b) Serious impairment to the person's bodily functions.

(c) Serious dysfunction of any of the person's bodily organs or parts.

SECTION 7. 609.01 (1d) of the statutes is repealed and recreated to read:

609.01 **(1d)** "Enrollee" means, with respect to a managed care plan, a person who is entitled to receive health care services under the plan.

SECTION 8. 609.01 (1p) of the statutes is created to read:

609.01 **(1p)** "Health care professional" means any individual licensed, registered, permitted or certified by the department of health and family services or

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

SECTION 9. 609.01 (2) of the statutes is amended to read:

609.01 **(2)** "Health maintenance organization" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its ~~enrolled participants~~ enrollees, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers ~~selected by the organization~~ participating in the plan.

SECTION 10. 609.01 (3) of the statutes is amended to read:

609.01 **(3)** "Limited service health organization" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its ~~enrolled participants~~ enrollees, in consideration for predetermined periodic fixed payments, a limited range of health care services performed by providers ~~selected by the organization~~ participating in the plan.

SECTION 11. 609.01 (3c) of the statutes is created to read:

609.01 **(3c)** "Managed care plan" means a health maintenance organization, limited service health organization or preferred provider plan.

SECTION 12. 609.01 (3m) of the statutes is created to read:

609.01 **(3m)** "Participating" means, with respect to a physician or other provider, under contract with a managed care plan to provide health care services, items or supplies to enrollees of the plan.

SECTION 13. 609.01 (3r) of the statutes is created to read:

609.01 **(3r)** "Physician" has the meaning given in s. 448.01 (5).

SECTION 14. 609.01 (4) of the statutes is amended to read:

609.01 **(4)** "Preferred provider plan" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its ~~enrolled participants~~ enrollees, for consideration other than predetermined periodic fixed payments, either comprehensive health care services or a limited range of health care services performed by providers ~~selected by the organization~~ participating in the plan.

SECTION 15. 609.01 (4m) of the statutes is created to read:

609.01 **(4m)** "Primary care physician" means a physician specializing in family medical practice, general internal medicine, obstetrics and gynecology or pediatrics.

SECTION 16. 609.01 (5) of the statutes is repealed and recreated to read:

609.01 **(5)** "Primary provider" means a participating health care professional who coordinates, supervises and may provide ongoing care to an enrollee.

SECTION 17. 609.01 (6) of the statutes is repealed and recreated to read:

609.01 **(6)** "Specialist physician" means a physician who is not a primary care physician.

SECTION 18. 609.01 (7) of the statutes is amended to read:

609.01 **(7)** "Standard plan" means a health care plan ~~other than a health maintenance organization or a preferred provider~~ that is not a managed care plan.

SECTION 19. 609.05 (1) of the statutes is amended to read:

609.05 **(1)** Except as provided in subs. (2) and (3), a ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan shall permit its ~~enrolled participants~~ enrollees to choose freely among ~~selected~~ participating providers.

SECTION 20. 609.05 (2) of the statutes is amended to read:

609.05 **(2)** ~~A health care plan under sub. (1)~~ Subject to s. 609.24 (2) and (3), a managed care plan may require an ~~enrolled participant~~ enrollee to designate a primary provider and to obtain health care services from the primary provider when reasonably possible.

SECTION 21. 609.05 (3) of the statutes is amended to read:

609.05 **(3)** Except as provided in ss. 609.65 and 609.655, a ~~health~~ managed care plan ~~under sub. (1)~~ may require an ~~enrolled participant~~ enrollee to obtain a referral from the primary provider designated under sub. (2) to another ~~selected~~ participating provider prior to obtaining health care services from ~~the other selected~~ that participating provider.

SECTION 22. 609.10 (1) (a) of the statutes is amended to read:

609.10 **(1)** (a) Except as provided in subs. (2) to (4), an employer that offers any of its employes a health maintenance organization or a preferred provider plan that provides comprehensive health care services shall also offer the employes a standard plan, as provided in pars. (b) and (c), that provides at least substantially equivalent coverage of health care expenses ~~and that is not a health maintenance organization or a preferred provider plan~~.

SECTION 23. 609.15 (1) (intro.) of the statutes is amended to read:

609.15 **(1)** (intro.) Each ~~health maintenance organization, limited service health organization and preferred provider~~ managed care plan shall do all of the following:

SECTION 24. 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) for the resolution of ~~enrolled participants'~~ enrollees' grievances with the ~~health~~ managed care plan.

SECTION 25. 609.15 (1) (b) of the statutes is amended to read:

609.15 **(1)** (b) Provide ~~enrolled participants~~ enrollees with complete and understandable information describing the internal grievance procedure under par. (a).

SECTION 26. 609.15 (2) (a) of the statutes is amended to read:

609.15 **(2)** (a) The opportunity for an ~~enrolled participant~~ enrollee to submit a written grievance in any form.

SECTION 27. 609.15 (2) (b) of the statutes is amended to read:

609.15 **(2)** (b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one ~~enrolled participant~~ enrollee other than the grievant, if an ~~enrolled participant~~ enrollee is available to serve on the grievance panel.

SECTION 28. 609.17 of the statutes is amended to read:

609.17 Reports of disciplinary action. Every ~~health maintenance organization, limited service health organization and preferred provider~~ managed care plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a ~~selected~~ participating provider who holds a license or certificate granted by the board or affiliated credentialing board.

SECTION 29. 609.20 (intro.) of the statutes is amended to read:

609.20 Rules for ~~preferred provider~~ managed care plans. (intro.) The commissioner shall promulgate rules ~~applicable to preferred provider plans~~ relating to managed care plans for all of the following purposes:

SECTION 30. 609.20 (1) of the statutes is amended to read:

609.20 **(1)** To ensure that ~~enrolled participants~~ enrollees are not forced to travel excessive distances to receive health care services.

SECTION 31. 609.20 (2) of the statutes is amended to read:

609.20 **(2)** To ensure that the continuity of patient care for ~~enrolled participants~~ enrollees is not disrupted.

SECTION 32. 609.20 (4) of the statutes is amended to read:

609.20 **(4)** To ensure that employes offered a health maintenance organization or a preferred provider plan that provides comprehensive services under s. 609.10 (1) (a) are given adequate notice of the opportunity to enroll and complete and understandable information under s. 609.10 (1) (c) concerning the differences between the health maintenance organization or preferred provider plan and the standard plan, including differences between providers available and differences resulting from special limitations or requirements imposed by an institutional provider because of its affiliation with a religious organization.

SECTION 33. 609.22 of the statutes is created to read:

609.22 Access to personnel and facilities. (1) PROVIDERS. A managed care plan shall include a sufficient number, and sufficient types, of primary care and specialist physicians throughout the service area of the plan to meet the anticipated needs of its enrollees and to provide its enrollees with a meaningful choice among physicians. A managed care plan shall offer all of the following:

(a) Adequate accessible acute care hospital services for all of its enrollees.

(b) An adequate number of accessible primary care physicians for all of its enrollees.

(c) Subject to sub. (2), an adequate number of accessible specialist physicians for all of its enrollees within a reasonable distance or travel time.

(d) The availability of specialty medical services, including physical therapy, occupational therapy and rehabilitation services.

(e) The availability of nonparticipating specialist physicians for enrollees whose medical conditions require services that cannot be provided by participating specialist physicians.

(2) NONPARTICIPATING SPECIALISTS. If the treatment of a specific condition requires the services of a particular type of specialist physician and a managed care plan has no participating specialist physicians of that type, the managed care plan shall provide enrollees with the specific condition with coverage for the services of nonparticipating specialist physicians of that type.

(3) TELEPHONE ACCESS. A managed care plan shall provide telephone access to the plan for sufficient time during business and evening hours to ensure that enrollees have adequate access to routine health care services. A managed care plan shall provide 24–hour telephone access to the plan or to a participating provider for emergency care or authorization for care.

(4) STANDARDS FOR APPOINTMENT SCHEDULING. A managed care plan shall establish standards for reasonable waiting times for obtaining appointments for health care services, except for emergency care. The standards shall include scheduling guidelines based on the type of health care service for which an appointment is being made.

(5) EMERGENCY CARE. A managed care plan shall cover, and reimburse expenses for, emergency care obtained without prior authorization for the treatment of an emergency medical condition.

(6) ACCESS PLAN FOR CERTAIN ENROLLEES. A managed care plan shall develop an access plan to meet the needs of its enrollees who are members of underserved

populations. The managed care plan shall provide culturally appropriate services to the greatest extent possible. If a significant number of enrollees of the plan customarily use languages other than English, the managed care plan shall provide access to personnel who are fluent in those languages to the greatest extent possible.

(7) ENROLLEES HELD HARMLESS FOR CLAIMS. A limited service health organization or a preferred provider plan shall hold an enrollee harmless against any claim from a participating provider for payment of any portion of the cost of covered health care services. This subsection does not affect the liability of an enrollee, policyholder or insured for any deductibles, copayments or premiums owed under the policy or certificate issued by the limited service health organization insurer or the preferred provider plan insurer. A health maintenance organization is subject to ss. 609.91 to 609.94.

SECTION 34. 609.24 of the statutes is created to read:

609.24 Choice of providers. (1) ADEQUATE CHOICE. A managed care plan shall ensure that each enrollee has adequate choice among participating providers and that the providers are accessible and qualified.

(2) PRIMARY PROVIDERS. Except as provided in sub. (3), a managed care plan shall permit each enrollee to select his or her own primary provider from a list of participating health care professionals. The list shall be updated on an ongoing basis and shall include all of the following:

(a) A sufficient number of health care professionals who are accepting new enrollees.

(b) A sufficient diversity of health care professionals to adequately meet the needs of an enrollee population with varied characteristics, including age, gender, race and health status.

(3) SPECIALIST PROVIDERS. (a) A managed care plan shall establish a system under which an enrollee with a chronic disease or other special needs may select a participating specialist physician as his or her primary provider.

(b) A managed care plan shall allow all enrollees under the plan to have access to specialist physicians on a timely basis when specialty medical care is warranted. An enrollee shall be allowed to choose among participating specialist physicians when a referral is made for specialty care.

(4) POINT-OF-SERVICE OPTION. A managed care plan shall offer a point–of–service option, under which an enrollee may obtain covered services from a nonparticipating provider of the enrollee's choice. Under the point–of–service option, the enrollee may be required to pay a reasonable portion of the cost of those services.

(5) SECOND OPINIONS. A managed care plan shall provide an enrollee with coverage for a 2nd opinion from another participating provider.

SECTION 35. 609.26 of the statutes is created to read:

609.26 Drugs and devices. (1) COVERAGE. (a) A managed care plan shall provide coverage of any drug or device that is approved for use by the federal food and drug administration and that is determined by a treating participating provider to be medically appropriate and necessary for treatment of an enrollee's condition, regardless of whether the drug or device is prescribed by the treating participating provider for the use for which the drug or device is approved by the federal food and drug administration.

(b) A treating participating provider shall determine the drug therapy that is appropriate for his or her patient.

(c) Prospective review of drug therapy may deny coverage only if any of the following apply:

1. A coverage limitation has been reached with respect to the enrollee.

2. The enrollee has committed fraud with respect to obtaining the drug.

(2) DRUG UTILIZATION REVIEW PROGRAM. (a) A managed care plan shall establish and operate a drug utilization review program. The primary goal of the program shall be to enhance quality of care for enrollees by ensuring appropriate drug therapy.

(b) The program under par. (a) shall include all of the following:

1. Retrospective review of prescription drugs furnished to enrollees.

2. Ongoing periodic examination of data on outpatient prescription drugs to ensure quality therapeutic outcomes for enrollees.

3. An educational outreach program for physicians, pharmacists and enrollees regarding the appropriate use of prescription drugs.

(c) The program under par. (a) shall utilize all of the following:

1. Clinically relevant criteria and standards for drug therapy.

2. Nonproprietary criteria and standards developed and revised through an open, professional consensus process.

3. Interventions that focus on improving therapeutic outcomes.

SECTION 36. 609.28 of the statutes is created to read:

609.28 Experimental treatment. (1) DISCLOSURE OF LIMITATIONS. A managed care plan that limits coverage for experimental treatment shall define the limitation and disclose the limits in any agreement or certificate of coverage. This disclosure shall include the following information:

(a) Who is authorized to make a determination on the limitation.

(b) The criteria the plan uses to determine whether a treatment, procedure, drug or device is experimental.

(2) DENIAL OF TREATMENT. If a managed care plan denies coverage of an experimental treatment, procedure, drug or device for an enrollee who has a terminal condition or illness, the managed care plan shall provide the enrollee with a denial letter within 20 working days after the request for coverage is submitted. The denial letter shall include all of the following:

(a) The name and title of the individual making the decision.

(b) A statement setting forth the specific medical and scientific reasons for denying coverage.

(c) A description of any alternative treatment, procedures, drugs or devices covered by the plan.

(d) A written copy of the plan's grievance and appeal procedure.

SECTION 37. 609.30 of the statutes is created to read:

609.30 Provider disclosures. (1) PLAN MAY NOT CONTRACT. A managed care plan may not contract with a participating provider to limit the provider's disclosure of information, to or on behalf of an enrollee, about the enrollee's medical condition or treatment options.

(2) PLAN MAY NOT PENALIZE OR TERMINATE. (a) A managed care plan may not penalize a participating provider for discussing with an enrollee financial incentives offered by the plan or other financial arrangements between the plan and the provider.

(b) A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provider determines to be in the best interest of the enrollee. A managed care plan may not penalize or terminate

the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee.

SECTION 38. 609.32 of the statutes is created to read:

609.32 Quality assurance. (1) STANDARDS. A managed care plan shall develop comprehensive quality assurance standards that are adequate to identify, evaluate and remedy problems related to access to, and continuity and quality of, care. The standards shall include at least all of the following:

(a) An ongoing, written internal quality assurance program.

(b) Specific written guidelines for quality of care studies and monitoring.

(c) Performance and clinical outcomes–based criteria.

(d) A procedure for remedial action to address quality problems, including written procedures for taking appropriate corrective action.

(e) A plan for gathering and assessing data.

(f) A peer review process.

(2) SELECTION AND EVALUATION OF PROVIDERS. (a) A managed care plan shall develop a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

(b) A managed care plan shall establish in writing a formal, ongoing process for reevaluating each participating provider within a specified number of years after

the provider's initial acceptance for participation. The reevaluation shall include all of the following:

1. Updating the previous review criteria.

2. Assessing the provider's performance on the basis of such criteria as enrollee clinical outcomes, number of complaints and malpractice actions.

(c) A managed care plan may not require a participating provider to provide services that are outside the scope of his or her license or certificate.

SECTION 39. 609.34 of the statutes is created to read:

609.34 Clinical decision-making. (1) MEDICAL DIRECTOR. A managed care plan shall appoint a physician as medical director. The medical director shall be responsible for treatment policies, protocols, quality assurance activities and utilization management decisions of the plan.

(2) INCENTIVES. A managed care plan shall inform enrollees of any financial arrangement between the plan and a participating physician or pharmacist that includes or operates as an incentive or a bonus for restricting services.

SECTION 40. 609.36 of the statutes is created to read:

609.36 Data systems and confidentiality. (1) INFORMATION AND DATA REPORTING. (a) A managed care plan shall provide to the commissioner information related to all of the following:

1. The structure of the plan.

2. The plan's decision–making process.

3. Health care benefits and exclusions.

4. Cost–sharing requirements.

5. Participating providers.

(b) A managed care plan shall collect and annually report to the commissioner the following data:

1. Gross outpatient and hospitalization data.

2. Enrollee clinical outcomes data.

(c) Subject to sub. (2), the information and data reported under pars. (a) and (b) shall be open to public inspection under ss. 19.31 to 19.39.

(2) CONFIDENTIALITY. A managed care plan shall establish written policies and procedures, consistent with ss. 51.30, 146.82 and 252.15, for the handling of medical records and enrollee communications to ensure confidentiality.

SECTION 41. 609.38 of the statutes is created to read:

609.38 Oversight. On an annual basis, the office shall perform audits of managed care plans in the state to review enrollee outcome data, enrollee service data and operational and other financial data. The commissioner shall by rule develop standards for managed care plans for compliance with the requirements under this chapter.

SECTION 42. 609.65 (1) (intro.) of the statutes is amended to read:

609.65 **(1)** (intro.) If an ~~enrolled participant of a health maintenance organization, limited service health organization or preferred provider~~ enrollee of a managed care plan is examined, evaluated or treated for a nervous or mental disorder pursuant to an emergency detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m) or (4r) or ch. 980, then, notwithstanding the limitations regarding ~~selected~~ participating providers, primary providers and referrals under ss. 609.01 (2) to (4) and 609.05 (3), the ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan shall do all of the following:

SECTION 43. 609.65 (1) (a) of the statutes is amended to read:

609.65 **(1)** (a) If the provider performing the examination, evaluation or treatment has a provider agreement with the ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan which covers the provision of that service to the ~~enrolled participant~~ enrollee, make the service available to the ~~enrolled participant~~ enrollee in accordance with the terms of the ~~health care~~ plan and the provider agreement.

SECTION 44. 609.65 (1) (b) (intro.) of the statutes is amended to read:

609.65 **(1)** (b) (intro.) If the provider performing the examination, evaluation or treatment does not have a provider agreement with the ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan which covers the provision of that service to the ~~enrolled participant~~ enrollee, reimburse the provider for the examination, evaluation or treatment of the ~~enrolled participant~~ enrollee in an amount not to exceed the maximum reimbursement for the service under the medical assistance program under subch. IV of ch. 49, if any of the following applies:

SECTION 45. 609.65 (1) (b) 1. of the statutes is amended to read:

609.65 **(1)** (b) 1. The service is provided pursuant to a commitment or a court order, except that reimbursement is not required under this subdivision if the ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan could have provided the service through a provider with whom it has a provider agreement.

SECTION 46. 609.65 (1) (b) 2. of the statutes is amended to read:

609.65 **(1)** (b) 2. The service is provided pursuant to an emergency detention under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20

and the provider notifies the ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan within 72 hours after the initial provision of the service.

SECTION 47. 609.65 (2) of the statutes is amended to read:

609.65 **(2)** If after receiving notice under sub. (1) (b) 2. the ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan arranges for services to be provided by a provider with whom it has a provider agreement, the ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan is not required to reimburse a provider under sub. (1) (b) 2. for any services provided after arrangements are made under this subsection.

SECTION 48. 609.65 (3) of the statutes is amended to read:

609.65 **(3)** A ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan is only required to make available, or make reimbursement for, an examination, evaluation or treatment under sub. (1) to the extent that the ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan would have made the medically necessary service available to the ~~enrolled participant~~ enrollee or reimbursed the provider for the service if any referrals required under s. 609.05 (3) had been made and the service had been performed by a participating provider ~~selected by the health maintenance organization, limited service health organization or preferred provider plan~~.

SECTION 49. 609.655 (2) of the statutes is amended to read:

609.655 **(2)** If a policy or certificate issued by a health maintenance organization provides coverage of outpatient services provided to a dependent

student, the policy or certificate shall provide coverage of outpatient services, to the extent and in the manner required under sub. (3), that are provided to the dependent student while he or she is attending a school located in this state but outside the geographical service area of the health maintenance organization, notwithstanding the limitations regarding ~~selected~~ participating providers, primary providers and referrals under ss. 609.01 (2) and 609.05 (3).

SECTION 50. 609.655 (5) (a) of the statutes is amended to read:

609.655 **(5)** (a) A policy or certificate issued by a health maintenance organization is required to provide coverage for the services specified in sub. (3) only to the extent that the policy or certificate would have covered the service if it had been provided to the dependent student by a ~~selected~~ participating provider within the geographical service area of the health maintenance organization.

SECTION 51. 609.655 (5) (b) of the statutes is amended to read:

609.655 **(5)** (b) Paragraph (a) does not permit a health maintenance organization to reimburse a provider for less than the full cost of the services provided or an amount negotiated with the provider, solely because the reimbursement rate for the service would have been less if provided by a ~~selected~~ participating provider within the geographical service area of the health maintenance organization.

SECTION 52. 609.70 of the statutes is amended to read:

609.70 Chiropractic coverage. ~~Health maintenance organizations, limited service health organizations and preferred provider~~ Managed care plans are subject to s. 632.87 (3).

SECTION 53. 609.75 of the statutes is amended to read:

609.75 Adopted children coverage. ~~Health maintenance organizations, limited service health organizations and preferred provider~~ Managed care plans are subject to s. 632.896. Coverage of health care services obtained by adopted children and children placed for adoption may be subject to any requirements that the ~~health maintenance organization, limited service health organization or preferred provider~~ managed care plan imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained by other ~~enrolled participants~~ enrollees.

SECTION 54. 609.80 of the statutes is amended to read:

609.80 Coverage of mammograms. Health maintenance organizations and preferred provider plans are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be subject to any requirements that the health maintenance organization or preferred provider plan imposes under s. 609.05 (2) and (3) on the coverage of other health care services obtained by ~~enrolled participants~~ enrollees.

SECTION 55. 609.81 of the statutes is amended to read:

609.81 Coverage related to HIV infection. ~~Health maintenance organizations, limited service health organizations and preferred provider~~ Managed care plans are subject to s. 631.93. Health maintenance organizations and preferred provider plans are subject to s. 632.895 (9).

SECTION 56. 609.91 (1) (intro.) of the statutes is amended to read:

609.91 **(1)** (title) IMMUNITY OF ~~ENROLLED PARTICIPANTS~~ ENROLLEES AND POLICYHOLDERS. (intro.) Except as provided in sub. (1m), an ~~enrolled participant~~ enrollee or policyholder of a health maintenance organization insurer is not liable for health care costs that are incurred on or after January 1, 1990, and that are covered under a policy or certificate issued by the health maintenance organization insurer, if any of the following applies:

SECTION 57. 609.91 (1) (b) 2. of the statutes is amended to read:

609.91 **(1)** (b) 2. Is physician services provided under a contract with the health maintenance organization insurer or by a ~~selected~~ participating provider of the health maintenance organization insurer.

SECTION 58. 609.91 (1) (b) 3. of the statutes is amended to read:

609.91 **(1)** (b) 3. Is services, equipment, supplies or drugs that are ancillary or incidental to services described in subd. 2. and are provided by the contracting provider or ~~selected~~ participating provider.

SECTION 59. 609.91 (1m) of the statutes is amended to read:

609.91 **(1m)** IMMUNITY OF MEDICAL ASSISTANCE RECIPIENTS. An ~~enrolled participant~~ enrollee, policyholder or insured under a policy issued by an insurer to the department of health and family services under s. 49.45 (2) (b) 2. to provide prepaid health care to medical assistance recipients is not liable for health care costs that are covered under the policy.

SECTION 60. 609.91 (2) of the statutes is amended to read:

609.91 **(2)** PROHIBITED RECOVERY ATTEMPTS. No person may bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an ~~enrolled participant~~ enrollee, policyholder or insured, or any person acting on their behalf, for health care costs for which the ~~enrolled participant~~ enrollee, policyholder or insured, or person acting on their behalf, is not liable under sub. (1) or (1m).

SECTION 61. 609.91 (3) of the statutes is amended to read:

609.91 **(3)** DEDUCTIBLES, COPAYMENTS AND PREMIUMS. Subsections (1) to (2) do not affect the liability of an ~~enrolled participant~~ enrollee, policyholder or insured for any deductibles, copayments or premiums owed under the policy or certificate issued by

the health maintenance organization insurer or by the insurer described in sub. (1m).

SECTION 62. 609.91 (4) (intro.) of the statutes is amended to read:

609.91 **(4)** (intro.) CONDITIONS NOT AFFECTING THE IMMUNITY. The immunity of an ~~enrolled participant~~ enrollee, policyholder or insured for health care costs, to the extent of the immunity provided under this section and ss. 609.92 to 609.935, is not affected by any of the following:

SECTION 63. 609.91 (4) (a) of the statutes is amended to read:

609.91 **(4)** (a) An agreement, other than a notice of election or termination of election in accordance with s. 609.92 or 609.925, entered into by the provider, the health maintenance organization insurer, the insurer described in sub. (1m) or any other person, at any time, whether oral or written and whether implied or explicit, including an agreement that purports to hold the ~~enrolled participant~~ enrollee, policyholder or insured liable for health care costs.

SECTION 64. 609.91 (4) (b) of the statutes is amended to read:

609.91 **(4)** (b) A breach of or default on an agreement by the health maintenance organization insurer, the insurer described in sub. (1m) or any other person to compensate the provider, directly or indirectly, for health care costs, including health care costs for which the ~~enrolled participant~~ enrollee, policyholder or insured is not liable under sub. (1) or (1m).

SECTION 65. 609.91 (4) (c) of the statutes is amended to read:

609.91 **(4)** (c) The insolvency of the health maintenance organization insurer or any person contracting with the health maintenance organization insurer or provider, or the commencement or the existence of conditions permitting the commencement of insolvency, delinquency or bankruptcy proceedings involving the

health maintenance organization insurer or other person, including delinquency proceedings, as defined in s. 645.03 (1) (b), under ch. 645, despite whether the health maintenance organization insurer or other person has agreed to compensate, directly or indirectly, the provider for health care costs for which the ~~enrolled participant~~ enrollee or policyholder is not liable under sub. (1).

SECTION 66. 609.91 (4) (cm) of the statutes is amended to read:

609.91 **(4)** (cm) The insolvency of the insurer described in sub. (1m) or any person contracting with the insurer or provider, or the commencement or the existence of conditions permitting the commencement of insolvency, delinquency or bankruptcy proceedings involving the insurer or other person, including delinquency proceedings, as defined in s. 645.03 (1) (b), under ch. 645, despite whether the insurer or other person has agreed to compensate, directly or indirectly, the provider for health care costs for which the ~~enrolled participant~~ enrollee, policyholder or insured is not liable under sub. (1m).

SECTION 67. 609.91 (4) (d) of the statutes is amended to read:

609.91 **(4)** (d) The inability of the provider or other person who is owed compensation for health care costs to obtain compensation from the health maintenance organization insurer, the insurer described in sub. (1m) or any other person for health care costs for which the ~~enrolled participant~~ enrollee, policyholder or insured is not liable under sub. (1) or (1m).

SECTION 68. 609.92 (5) of the statutes is amended to read:

609.92 **(5)** PROVIDER OF PHYSICIAN SERVICES. A provider who is not under contract with a health maintenance organization insurer and who is not a ~~selected~~ participating provider of a health maintenance organization insurer is not subject

to s. 609.91 (1) (b) 2. with respect to health care costs incurred by an ~~enrolled participant~~ enrollee of that health maintenance organization insurer.

SECTION 69. 609.94 (1) (b) of the statutes is amended to read:

609.94 **(1)** (b) Each ~~selected~~ participating provider of the health maintenance organization insurer, at the time that the provider becomes a ~~selected~~ participating provider.

SECTION 70. 645.69 (1) of the statutes is amended to read:

645.69 **(1)** A claim against a health maintenance organization insurer or an insurer described in s. 609.91 (1m) for health care costs, as defined in s. 609.01 (1j), for which an ~~enrolled participant~~ enrollee, as defined in s. 609.01 (1d), policyholder or insured of the health maintenance organization insurer or other insurer is not liable under ss. 609.91 to 609.935.

SECTION 71. 645.69 (2) of the statutes is amended to read:

645.69 **(2)** A claim for health care costs, as defined in s. 609.01 (1j), for which an ~~enrolled participant~~ enrollee, as defined in s. 609.01 (1d), or policyholder of a ~~health maintenance organization~~ managed care plan, as defined in s. 609.01 (3c), is not liable for any reason.

SECTION 72. 646.31 (1) (d) 8. of the statutes is amended to read:

646.31 **(1)** (d) 8. Made for health care costs, as defined in s. 609.01 (1j), for which an ~~enrolled participant~~ enrollee, as defined in s. 609.01 (1d), or policyholder of a health maintenance organization insurer is not liable under ss. 609.91 to 609.935.

SECTION 73. 646.31 (1) (d) 9. of the statutes is amended to read:

646.31 **(1)** (d) 9. Made for health care costs, as defined in s. 609.01 (1j), for which an ~~enrolled participant~~ enrollee, as defined in s. 609.01 (1d), or policyholder of a

~~health maintenance organization~~ managed care plan, as defined in s. 609.01 (3c), is not liable for any reason.

SECTION 74. Initial applicability.

(1) If a contract that is in effect on January 1, 1999, that is affected by this act and that was not issued or renewed after the effective date of this subsection contains terms or provisions that are inconsistent with the requirements under this act, this act first applies to that contract upon renewal.

(2) If a contract that is in effect on January 1, 1999, that is affected by this act and that is affected by a collective bargaining agreement that was not extended, modified or renewed after the effective date of this subsection contains terms or provisions that are inconsistent with this act, this act first applies to that contract on the earlier of the following:

(a) The day on which the collective bargaining agreement expires.

(b) The day on which the collective bargaining agreement is extended, modified or renewed.

SECTION 75. Effective dates. This act takes effect on January 1, 1999, or on the day after publication, whichever is later, except as follows:

(1) SECTION 74 of this act takes effect on the day after publication.

(END)