State of Wisconsin
1997 - 1998 LEGISLATURE

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1997 ASSEMBLY BILL 927

March 17, 1998 - Introduced by Representatives LADWIG, R. POTTER, OWENS, WASSERMAN, BALDWIN, BLACK, BOCK, BRANDEMUEHL, CARPENTER, DOBYNS, GUNDERSON, HAHN, HEBL, JOHNSRUD, J. LEHMAN, LINTON, MUSSER, NOTESTEIN, OLSEN, OTT, PLALE, PORTER, ROBSON, RYBA, SERATTI and VANDER LOOP, cosponsored by Senators ROESSLER, WIRCH, ROSENZWEIG, C. POTTER, SCHULTZ, WELCH, DRZEWIECKI, DARLING and PANZER. Referred to Committee on Managed Care.

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 (1) (a) 1., 609.655 (1) (a) 2., 609.655 (2), 609.655 (3) (intro.), 609.655 (3) (a), 609.655 (3) (b) (intro.), 609.655 (3) (b) 1., 609.655 (4) (a), 609.655 (4) (b), 609.655 (5) (a), 609.655 (5) (b), 609.70, 609.75, 609.77, 609.78, 609.79, 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), chapter 609 (title), 609.01 (1d), 609.01 (5) and 609.01 (6); and ***to create*** 40.51 (13), 609.01 (1c), 609.01 (1g), 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. Those requirements address when an employer must offer a standard plan in addition to a health maintenance organization or preferred provider plan; coverage under a health maintenance organization for certain services for a child who is away at school; reporting disciplinary action taken against a participating provider of a health maintenance organization, preferred provider plan or limited service health organization; and a grievance procedure that all health maintenance organizations, preferred provider plans and limited service health organizations must establish. This bill provides for additional requirements for managed care plans, which are defined in the bill as health benefit plans that create incentives for plan enrollees to use providers that are managed, owned, under contract with or employed by the plan. Under the bill, health maintenance organizations and preferred provider plans are managed care plans, but limited service health organizations are not.

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 providers to meet the anticipated needs of its enrollees, with respect to covered benefits. 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. If a managed care plan covers emergency care, it may not require prior authorization for such care. In addition, a managed care plan must cover emergency care for a dependent child who is attending school away from home, regardless of where the emergency care is provided.

A managed care plan must permit an enrollee to choose a primary provider from a list of participating providers that is updated on an ongoing basis. 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.

With certain exceptions, a managed care plan must provide coverage for the services of a provider that the plan represented in marketing materials would be a participating provider, regardless of whether the provider is a participating provider at the time that the services are rendered. The coverage is required until the end of the plan year for which the plan represented that the provider would be a participating provider. If the provider is a specialist physician who is providing a course of treatment to an enrollee when the provider's participation in the plan

terminates, the plan must provide coverage for the provider's services only until the course of treatment is completed or for 90 days after the provider's participation ends, whichever is sooner.

If a managed care plan provides coverage for prescribed drugs or devices, the plan may not deny coverage for a prescribed drug or device that is approved by the federal food and drug administration solely on the basis that the drug or device is being used for a purpose for which it has not been approved by the federal food and drug administration. A managed care plan that covers only certain prescribed drugs or devices must cover any other prescribed drug or device whenever the drug or device is medically necessary.

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. The plan must make a coverage decision within 5 days after receiving a request for prior authorization of an experimental procedure. Whenever coverage for experimental treatment is denied, the plan must provide the enrollee with a denial letter that informs the enrollee of who made the coverage decision, the reasons for the denial and the enrollee's right to appeal the decision.

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 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.

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), and every limited service health organization, as defined in s. 609.01 (3), 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), and every limited service health organization, as defined in s. 609.01 (3), 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, 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 is not liable to any person under s. 609.91.

SECTION 5. Chapter 609 (title) of the statutes is repealed and recreated to read:

CHAPTER 609

MANAGED CARE PLANS

SECTION 6. 609.01 (1) of the statutes is repealed.

SECTION 7. 609.01 (1c) of the statutes is created to read:

609.01 **(1c)** "Emergency medical condition" means a medical condition that manifests itself by acute 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 8. 609.01 (1d) of the statutes is repealed and recreated to read:

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

SECTION 9. 609.01 (1g) of the statutes is created to read:

609.01 **(1g)** (a) Except as provided in par. (b), "health benefit plan" means any hospital or medical policy or certificate.

(b) "Health benefit plan" does not include any of the following:

1. Coverage that is only accident or disability income insurance, or any combination of the 2 types.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Worker's compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit–only insurance.

7. Coverage for on–site medical clinics.

8. Other similar insurance coverage, as specified in regulations issued by the federal department of health and human services, under which benefits for medical care are secondary or incidental to other insurance benefits.

9. If provided under a separate policy, certificate or contract of insurance, or if otherwise not an integral part of the policy, certificate or contract of insurance: limited–scope dental or vision benefits; benefits for long–term care, nursing home care, home health care, community–based care, or any combination of those benefits; and such other similar, limited benefits as are specified in regulations issued by the federal department of health and human services under section 2791 of P.L. 104–191.

10. Hospital indemnity or other fixed indemnity insurance or coverage only for a specified disease or illness, if all of the following apply:

a. The benefits are provided under a separate policy, certificate or contract of insurance.

b. There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

c. Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

11. Other insurance exempted by rule of the commissioner.

SECTION 10. 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 11. 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 12. 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 13. 609.01 (3c) of the statutes is created to read:

609.01 **(3c)** "Managed care plan" means a health benefit plan that requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with or employed by the insurer offering the health benefit plan. The term includes a health maintenance organization and a preferred provider plan, but does not include a limited service health organization.

SECTION 14. 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 or limited service health

organization to provide health care services, items or supplies to enrollees of the plan.

SECTION 15. 609.01 (3r) of the statutes is created to read:

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

SECTION 16. 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 17. 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 18. 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 19. 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 20. 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 21. 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 22. 609.05 (2) of the statutes is amended to read:

609.05 **(2)** ~~A~~ Subject to s. 609.22 (4), a health care plan under sub. (1) 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 23. 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 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 24. 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 25. 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 26. 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 care plan.

SECTION 27. 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 28. 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 29. 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 30. 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 31. 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 32. 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 33. 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 34. 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~~, as well as 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 35. 609.22 of the statutes is created to read:

609.22 Access standards. (1) PROVIDERS. A managed care plan shall include a sufficient number, and sufficient types, of providers to meet the anticipated needs of its enrollees, with respect to covered benefits.

(2) 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.

(3) SPECIALIST PROVIDERS. (a) 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, with respect to covered benefits. An enrollee shall be allowed to choose among participating specialist physicians when a referral is made for specialty care, with respect to covered benefits.

(b) If the treatment of a specific condition for which coverage is provided under the plan 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.

(4) PRIMARY PROVIDER SELECTION. (a) Subject to par. (b), 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 a sufficient number of health care professionals who are accepting new enrollees.

(b) A managed care plan shall establish a system under which an enrollee with a chronic disease or other special needs for which coverage is provided under the plan may select a participating specialist physician as his or her primary provider.

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

(6) EMERGENCY CARE. If a managed care plan provides coverage of emergency services, with respect to covered benefits, the managed care plan shall do all of the following:

(a) Cover, and reimburse expenses for, emergency care for which coverage is provided under the plan and that is obtained without prior authorization for the treatment of an emergency medical condition.

(b) Cover, and reimburse expenses for, emergency or urgent care for which coverage is provided under the plan and that is provided to an individual who has coverage under the plan as a dependent child and who is a full–time student attending school outside of the geographic service area of the plan, regardless of where the care is provided.

(7) 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 for which coverage is provided under the plan. 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, for which coverage is provided under the plan.

(8) ACCESS PLAN FOR CERTAIN ENROLLEES. A managed care plan shall develop an access plan to meet the needs, with respect to covered benefits, of its enrollees who are members of underserved populations. 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.

SECTION 36. 609.24 of the statutes is created to read:

609.24 Continuity of care. (1) REQUIREMENT TO PROVIDE ACCESS. (a) Subject to pars. (b) and (c) and except as provided in par. (d), a managed care plan shall provide coverage to an enrollee for the services of a provider, regardless of whether the provider is a participating provider at the time the services are provided, if the

managed care plan represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the enrollee at any of the following times:

1. If the plan under which the enrollee has coverage has an open enrollment period, the most recent open enrollment period.

2. If the plan under which the enrollee has coverage has no open enrollment period, the time of the enrollee's enrollment or most recent coverage renewal, whichever is later.

(b) Except as provided in pars. (c) and (d), a managed care plan shall provide the coverage required under par. (a) for the following period of time:

1. For an enrollee of a plan with no open enrollment period, until the end of the current plan year.

2. For an enrollee of a plan with an open enrollment period, until the end of the plan year for which it was represented that the provider was, or would be, a participating provider.

(c) Except as provided in par. (d), if an enrollee is undergoing a course of treatment with a participating provider who is a specialist physician and whose participation with the plan terminates, the managed care plan is required to provide the coverage under par. (a) only for the remainder of the course of treatment, or for 90 days after the provider's participation with the plan terminates, whichever is shorter.

(d) The coverage required under par. (a) need not be provided or may be discontinued if any of the following applies:

1. The provider is a health care professional who no longer practices in the managed care plan's geographic service area.

2. The insurer issuing the managed care plan terminates or terminated the provider's contract for misconduct on the part of the provider.

(e) An insurer issuing a managed care plan shall include in its provider contracts provisions that are reasonable or necessary for compliance with this section.

(2) MEDICAL NECESSITY PROVISIONS. This section does not preclude the application of any provisions related to medical necessity that are generally applicable under the plan.

SECTION 37. 609.26 of the statutes is created to read:

609.26 Drugs and devices. (1) (a) In this subsection, "off–label use" means a use that is not approved by the federal food and drug administration for a drug or device that is approved by the federal food and drug administration.

(b) A managed care plan that provides coverage of prescription drugs or devices may not deny coverage of a prescribed drug or device solely on the basis that the drug or device is prescribed for an off–label use.

(2) A managed care plan that provides coverage of only certain specified prescription drugs or devices shall provide coverage of any other prescription drug or device whenever the drug or device is medically necessary.

SECTION 38. 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. A managed care plan that receives a request for prior authorization of an experimental procedure that includes sufficient information upon which to make a decision shall, within 5 days after receiving the request, issue a coverage decision. If the 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, as part of its coverage decision, provide the enrollee with a denial letter that includes 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) Notice of the enrollee's right to appeal and a description of the appeal procedure.

SECTION 39. 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 40. 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 41. 609.34 of the statutes is created to read:

609.34 Clinical decision–making; 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.

SECTION 42. 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) Subject to sub. (2), the information and data reported under par. (a) 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 43. 609.38 of the statutes is created to read:

609.38 Oversight. The office shall perform examinations of insurers that issue managed care plans consistent with ss. 601.43 and 601.44. The commissioner shall by rule develop standards for managed care plans for compliance with the requirements under this chapter.

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

609.65 **(1)** (intro.) If an ~~enrolled participant of a health maintenance organization,~~ enrollee of a limited service health organization or ~~preferred provider~~ 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 45. 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 46. 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 47. 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 48. 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 49. 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 50. 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 51. 609.655 (1) (a) 1. of the statutes is amended to read:

609.655 **(1)** (a) 1. Is covered as a dependent child under the terms of a policy or certificate issued by a ~~health maintenance organization~~ managed care plan insurer.

SECTION 52. 609.655 (1) (a) 2. of the statutes is amended to read:

609.655 **(1)** (a) 2. Is enrolled in a school located in this state but outside the geographical service area of the ~~health maintenance organization~~ managed care plan.

SECTION 53. 609.655 (2) of the statutes is amended to read:

609.655 **(2)** If a policy or certificate issued by a ~~health maintenance organization~~ managed care plan insurer 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~~ managed care plan, notwithstanding the limitations regarding ~~selected~~ participating providers, primary providers and referrals under ss. 609.01 (2) and 609.05 (3).

SECTION 54. 609.655 (3) (intro.) of the statutes is amended to read:

609.655 **(3)** (intro.) Except as provided in sub. (5), a ~~health maintenance organization~~ managed care plan shall provide coverage for all of the following services:

SECTION 55. 609.655 (3) (a) of the statutes is amended to read:

609.655 **(3)** (a) A clinical assessment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems, conducted by a provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and who may be designated by the ~~health maintenance organization~~ managed care plan.

SECTION 56. 609.655 (3) (b) (intro.) of the statutes is amended to read:

609.655 **(3)** (b) (intro.) If outpatient services are recommended in the clinical assessment conducted under par. (a), the recommended outpatient services consisting of not more than 5 visits to an outpatient treatment facility or other provider that is located in this state and in reasonably close proximity to the school

in which the dependent student is enrolled and that may be designated by the ~~health maintenance organization~~ managed care plan, except as follows:

SECTION 57. 609.655 (3) (b) 1. of the statutes is amended to read:

609.655 **(3)** (b) 1. Coverage is not required under this paragraph if the medical director of the ~~health maintenance organization~~ managed care plan determines that the nature of the treatment recommended in the clinical assessment will prohibit the dependent student from attending school on a regular basis.

SECTION 58. 609.655 (4) (a) of the statutes is amended to read:

609.655 **(4)** (a) Upon completion of the 5 visits for outpatient services covered under sub. (3) (b), the medical director of the ~~health maintenance organization~~ managed care plan and the clinician treating the dependent student shall review the dependent student's condition and determine whether it is appropriate to continue treatment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems in reasonably close proximity to the school in which the student is enrolled. The review is not required if the dependent student is no longer enrolled in the school or if the coverage limits under the policy or certificate for treatment of nervous or mental disorders or alcoholism or other drug abuse problems have been exhausted.

SECTION 59. 609.655 (4) (b) of the statutes is amended to read:

609.655 **(4)** (b) Upon completion of the review under par. (a), the medical director of the ~~health maintenance organization~~ managed care plan shall determine whether the policy or certificate will provide coverage of any further treatment for the dependent student's nervous or mental disorder or alcoholism or other drug abuse problems that is provided by a provider located in reasonably close proximity to the school in which the student is enrolled. If the dependent student disputes the

medical director's determination, the dependent student may submit a written grievance under the ~~health maintenance organization's~~ managed care plan's internal grievance procedure established under s. 609.15.

SECTION 60. 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~~ managed care plan insurer 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~~ managed care plan.

SECTION 61. 609.655 (5) (b) of the statutes is amended to read:

609.655 **(5)** (b) Paragraph (a) does not permit a ~~health maintenance organization~~ managed care plan 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~~ managed care plan.

SECTION 62. 609.70 of the statutes is amended to read:

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

SECTION 63. 609.75 of the statutes is amended to read:

609.75 Adopted children coverage. ~~Health maintenance organizations, limited~~ 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 64. 609.77 of the statutes, as created by 1997 Wisconsin Act 27, is amended to read:

609.77 Coverage of breast reconstruction. ~~Health maintenance organizations, limited~~ Limited service health organizations and ~~preferred provider~~ managed care plans are subject to s. 632.895 (13).

SECTION 65. 609.78 of the statutes, as created by 1997 Wisconsin Act 27, is amended to read:

609.78 Coverage of treatment for the correction of temporomandibular disorders. ~~Health maintenance organizations, limited~~ Limited service health organizations and ~~preferred provider~~ managed care plans are subject to s. 632.895 (11).

SECTION 66. 609.79 of the statutes, as created by 1997 Wisconsin Act 27, is amended to read:

609.79 Coverage of hospital and ambulatory surgery center charges and anesthetics for dental care. ~~Health maintenance organizations, limited~~ Limited service health organizations and ~~preferred provider~~ managed care plans are subject to s. 632.895 (12).

SECTION 67. 609.80 of the statutes is amended to read:

609.80 Coverage of mammograms. ~~Health maintenance organizations and preferred provider~~ Managed care 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~~ managed care plan imposes under s. 609.05 (2) and (3) on the coverage of other health care services obtained by ~~enrolled participants~~ enrollees.

SECTION 68. 609.81 of the statutes is amended to read:

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

SECTION 69. 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 70. 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 71. 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 72. 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 73. 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 74. 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 75. 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 76. 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 77. 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 78. 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 79. 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 80. 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 81. 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 82. 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 83. 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 84. 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 is not liable for any reason.

SECTION 85. 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 86. 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 is not liable for any reason.

SECTION 87. 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 88. Effective dates. This act takes effect on January 1, 1999, or on the day after publication, whichever is later, except as follows:

(1) SECTION 87 of this act takes effect on the day after publication.

(END)