WPS

WISCONSIN PHYSICIANS SERVICE • 1717 W. BROADWAY • BOX 8190 • MADISON, WISCONSIN 53708 • (608) 221-4711

December 17, 1999

The Honorable Rodney Moen
Chair, Senate Committee on Health, Utilities, Veterans and Military Affairs
State Capitol, Room 8 South
Madison, WI 53708

Dear Senator Moen:

I am writing with regard to CR 98-183, which is the proposed order of the Commissioner of Insurance relating to "revising requirements for managed care plans and limited service health organization plans to comply with recent changes in state law" that is presently before your Committee.

As you know, WPS has been concerned since this rule was first circulated for comment nearly a year ago that the proposed rule:

> Treats preferred provider plans as if they are managed care plans, which they are not.
>
> Requires preferred provider plans to assume managed care responsibilities for access to care, and for quality assurance and other matters relating to delivery of care that are not within the scope of preferred provider plan benefits and coverage.

We have reviewed a draft of proposed changes to the rule prepared by the Office of the Commissioner of Insurance and circulated for review on December 14, 1999. Many of these changes are changes that we are seeing for the first time. None of the changes to the proposed rule in this latest draft resolve the central problem in the rule, as we see it, which is that preferred provider plans are not managed care plans and should not be regulated as if they are. Moreover, this latest draft, in our opinion, creates new problems. It allows some insurers an exemption from regulation under the rule for certain narrowly defined preferred provider plans on the condition that these insurers do not *represent* the coverage offered as preferred provider plan coverage. This permits quite similar preferred provider plan coverage to be offered by one insurer as preferred provider plan coverage, and by another insurer as if it is not preferred provider plan coverage.

In our opinion, this is not a rule that is designed to regulate the marketplace; it is a rule that is designed to define, indeed to redefine the marketplace. If this rule goes forward, it will drive preferred provider plan coverage out of the marketplace.

It is the position of the Office of the Commissioner of Insurance that their reading of statutes does not permit them to resolve this problem. If the statutes are the problem, then the statutes need to be fixed.

We respectfully urge you not to let the rule go forward.

Sincerely yours,

Robert T. Wood
Corporate Vice President, Government Relations

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WISCONSIN PHYSICIANS SERVICE ▪ 1717 W. BROADWAY ▪ BOX 8190 ▪ MADISON, WISCONSIN 53708 ▪ (608) 221-4711

December 17, 1999

The Honorable Gregg Underheim
Chair, Assembly Committee on Health
State Capitol, Room 11 North
Madison, WI 53708

Dear Representative Underheim:

I am writing with regard to CR 98-183, which is the proposed order of the Commissioner of Insurance relating to "revising requirements for managed care plans and limited service health organization plans to comply with recent changes in state law" that is presently before your Committee.

As you know, WPS has been concerned since this rule was first circulated for comment nearly a year ago that the proposed rule:

> Treats preferred provider plans as if they are managed care plans, which they are not.
>
> Requires preferred provider plans to assume managed care responsibilities for access to care, and for quality assurance and other matters relating to delivery of care that are not within the scope of preferred provider plan benefits and coverage.

We have reviewed a draft of proposed changes to the rule prepared by the Office of the Commissioner of Insurance and circulated for review on December 14, 1999. Many of these changes are changes that we are seeing for the first time. None of the changes to the proposed rule in this latest draft resolve the central problem in the rule, as we see it, which is that preferred provider plans are not managed care plans and should not be regulated as if they are. Moreover, this latest draft, in our opinion, creates new problems. It allows some insurers an exemption from regulation under the rule for certain narrowly defined preferred provider plans on the condition that these insurers do not *represent* the coverage offered as preferred provider plan coverage. This permits quite similar preferred provider plan coverage to be offered by one insurer as preferred provider plan coverage, and by another insurer as if it is not preferred provider plan coverage.

In our opinion, this is not a rule that is designed to regulate the marketplace; it is a rule that is designed to define, indeed to redefine the marketplace. If this rule goes forward, it will drive preferred provider plan coverage out of the marketplace.

It is the position of the Office of the Commissioner of Insurance that their reading of statutes does not permit them to resolve this problem. If the statutes are the problem, then the statutes need to be fixed.

We respectfully urge you not to let the rule go forward.

Sincerely yours,

Robert T. Wood
Corporate Vice President, Government Relations

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WISCONSIN PHYSICIANS SERVICE ▪ 1717 W. BROADWAY ▪ BOX 8190 ▪ MADISON, WISCONSIN 53708 ▪ (608) 221-4711

December 17, 1999

The Honorable Connie L. O'Connell
Commissioner of Insurance
Office of the Commissioner of Insurance
121 East Wilson Street
Madison, WI 53702

Dear Commissioner O'Connell:

We appreciated your circulation of the revised draft of CR 98-183 for review on December 14, 1999.

As you will know, many of the changes in the revised draft are changes that we are seeing for the first time.

More importantly, none of the changes to the proposed rule in this latest draft resolve the central problem in the rule, as we see it, which is that preferred provider plans are not managed care plans and should not be regulated as if they are.

In addition, this latest draft, in our opinion, also creates several new problems.

We are particularly troubled by *limited exemption* language in redrafted *Ins 9.32 (1) (a) b.2.* and more broadly by the *Ins 9.32 (2) De Minimus Limited Exception*, which would appear to permit quite similar preferred provider plan coverage to be offered by one insurer as preferred provider plan coverage subject to burdensome, costly and inappropriate regulation, and by another insurer under a *de minimus exemption* as if it is not preferred provider plan coverage, and without regulation.

We urge you not to consider your December 14, 1999 draft a final draft, and to continue the process of modification of the rule.

Failing this, we will urge the legislative committees with present jurisdiction not to let the rule go forward.

Copies of correspondence to this effect are attached herewith for your information.

Sincerely yours,

Robert T. Wood
Corporate Vice President, Government Relations

IBA
WISCONSIN

Independent Business Association of Wisconsin

Washington Square Building
1400 East Washington Ave., Ste. 282
Madison, WI 53703

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800-362-8027
608-251-5952 FAX
email: iba@execpc.com
http://www.execpc.com/~iba/

TO: Members, Assembly Health Committee
Members, Senate Health, Utilities, Veterans and Military Affairs

FROM: Steve Miller, Chair
IBA Health Care Committee

DATE: December 8, 1999

RE: Administrative Rule Proposal to Create Ins 3.39(7)(g), Ins 3.39 (30) (r) Ins 3.67, Ins 6.11(3)(b) 4., and ch. Ins 9, Wis. Adm. Code

The IBA wishes to voice our concerns regarding the proposed administrative rule drafts relating to managed care plans and limited service health organization plans.

We believe they will have a negative impact on the ability of Wisconsin corporations to control health benefit plan costs. Increases in these costs will force businesses to increase employee contributions, decrease benefits, or terminate existing benefits plans.

Preferred Provider Organizations (PPOs) have played a key role in controlling health care costs this past decade. Currently, PPOs represent over 60% of the private sector, HMOs represent less than 30%.

Unlike HMOs, PPOs succeed and offer choices because they are reliant on the free market where open systems allow employees to retain complete freedom of choice.

Each employee and each dependent retains the right, each time they receive health care, to use a PPO provider or not. They have complete freedom to move within the system -- or to go outside the PPO.

This places consumer driven incentives on health care providers to provide a quality health care service on a timely basis. Further, if a service is not available through the PPO, the employee can step outside the PPO and, using non-PPO benefits, receive services.

HMOs have lobbied to include PPOs in the definition of plans knowing that such inclusion would cripple a competitor. The implementation of these regulations would require PPOs to re-contract with every single provider, a significant investment of time and resources. In addition, some PPOs may not be able to afford such an investment. At the very least, several months would be required to comply with a regulation that is unnecessary, counterproductive, and very costly.

A loss of access to PPO discounts would force insurance carriers to increase premium costs by 15% to 20%.

The Independent Business Association urges you to support action to remove PPOs from inclusion in this rule.

SM/jed

iba/health comm 12-8-99 memo

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Connie L. O'Connell
Commissioner

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http://badger.state.wi.us/agencies/oci/oci_home.htm

October 22, 1999

Honorable Rodney C. Moen
State Senator
8 South State Capitol
Madison WI 53702

RE: Clearinghouse Rule 98-183

Dear Senator Moen:

We received your letter regarding Clearinghouse Rule 98-183, and the Senate Health Committee request that the Office of the Commissioner of Insurance modify the rule.

We agree with the Committee that the rule can be improved with additional changes. As you know, we are negotiating with interested parties on modications to the rule language. We will keep the Committee apprised of any rule changes that are made.

Please feel free to contact my office if you have any additional concerns.

Sincerely,

Connie O'Connell

Connie L. O'Connell
Commissioner

Humana Inc.
1100 Employers Boulevard
Green Bay, WI 54344
800 558 4444 Toll-Free

OCT 2 2 1999

October 19, 1999

HUMANA

Senator Rodney Moen, Chair
Senate Health, Utilities, Veterans and Military Affairs
P.O. Box 7882
Madison, WI 53707

Dear Chairperson Moen:

It was a pleasure to appear before the committee at its October 13 hearing on Clearinghouse Rule 98-138 regarding managed care requirements. Enclosed is written testimony regarding the proposed regulation. Humana is participating in discussions with the committee chairs, OCI and health plans.

If you have any questions, please let me know (920-337-5618).

Sincerely,

Allan R. Patek
Senior Director
State Government Affairs

ARP/jch

Enc

Humana Inc.
1100 Employers Boulevard
Green Bay, WI 54344
800 558 4444 Toll-Free

Clearinghouse Rule 98-138 – Managed Care Requirements

Comments to the Senate Committee on Health, Utilities, Veterans and Military Affairs

Submitted by: Humana

Humana has concerns with certain provisions in the current draft of Clearinghouse Rule 98-138. Humana supports the intent of the proposed rule and appreciates modifications that the department made through the course of its deliberations. However, we cannot support it in its current form and believe several significant issues need to be addressed. A number of these concerns are the subject of discussions between the interested parties, OCI and the legislative committees. We hope they can be resolved so that we can support the proposed regulation.

Among the major changes we recommend are:

- **Limiting the application of the rule to only managed care plans;**
- **Providing notices to only those members affected by changes;**
- **Eliminating premature notices to members of provider terminations; and**
- **Eliminate the costly mailing of provider directories.**

Outlined below are our specific concerns and recommended changes.

INS 9.01 (12) Definition of "managed care plan"
Current Language: (12) "Managed care plan" has the meaning provided under s. 609.01 (3c), Stats., and includes Medicare Select policies as defined in s. 3.39 (30) (b) 4., and health benefit plans that either directly or indirectly contract for use of providers.

Recommended Change: (12) "Managed care plan" has the meaning provided under s. 609.01 (3c), Stats., and includes Medicare Select policies as defined in s. 3.39 (30) (b) 4., and health benefit plans *that vary covered services or cost sharing based on the use of specified providers.*

Rationale: Humana believes that the definition in the rule goes beyond legislative intent and does not address the concept of *incentives* that are used by a health benefit plan. The legislative intent was to apply the new standards established in Chapter 609 to health benefit plans that use differences in either benefits or cost sharing to *influence* a health plan members' choice of providers at or before the point of service. The definition of a managed care plan, health

maintenance organization and preferred provider plans all recognize the use of incentives.

As written, all discounted fee arrangements between health plans and providers are subject to certain provisions of the rule including network adequacy and continuity. Discounted fee arrangements are decidedly different than a plan's preferred provider or HMO network. Preferred networks are marketed to members as a key plan feature. Members are provided this preferred list of health care providers in advance of seeking service and benefit and cost sharing incentives steer the member to these preferred providers. We support requiring these regulations being applied to all network arrangements that conduct these activities consistent with the statutory definition of a managed care plan.

However, we believe applying the standards contained in Subchapter III of the rule to discounted fee arrangements exceeds the statutory authority and causes harm to consumers. Each year, we are able to save members money by accessing or negotiating situation discounts on provider charges. These fee discounts do benefit the consumer through reduced net costs, resulting in lower out-of-pocket expenses. However, the consumer is not required by the plan provisions to access preferred providers to receive benefits (including indemnity and the out-of-network benefits provided under PPO and POS products). The plan creates no benefit or cost sharing level incentive for the member at or prior to the point of service to use a certain provider. Members may select the provider of their choice and we access the discount. Unfortunately, if the provisions of this rule stand without modification we believe OCI will make us comply with the provisions of Subchapter III. Since these discounted fee arrangements are not designed for benefit steerage and often are difficult to obtain from health care providers, this program could not comply with the network adequacy, provider directory and continuity provisions of the regulation. We would be forced to cease using these arrangements and members would pay more as a result of the discounted savings being lost.

INS 9.34 (2) (c) Access Standards

Current Language: Provide 24-hour nationwide toll-free telephone access for its enrollees.

Recommended Clarification: Insert language to clarify that a 24-hour nurse hotline meets this access requirement.

INS 9.35 (1) Continuity of Care

Current Language: Upon termination of a provider from a managed care plan, the plan shall appropriately notify all enrollees of the termination, provide information on substitute providers, and at least identify the terminated providers within a separate section of the annual provider directory.

Recommended Change: Insert the term "affected" after "all" and before "enrollees." Phrase will read, "...the plan shall appropriately notify all affected enrollees of the termination..."

Rationale: Sending notice to *all* enrollees adds administrative costs to our plans without adding any additional consumer protections. We believe that health plans should be required to notify all *affected* enrollees of the termination. Affected enrollees include those who have received treatment or are currently receiving treatment from that provider. It would cost Humana with its 200,475 members an **additional $416,100 in administrative costs annually** to provide notices to all members. In most cases the notices would go to members that are not affected by the change. In some cases notice would be going to members residing on the other side of the state from the terminating provider since the rule does not limit the notice to a service area (Humana's HMO and PPO service areas include counties covering the state from Kenosha to Superior and Lake Michigan to the Mississippi River.)

Sub. (1) (a)

Current Language: If the terminating provider is a primary provider and the managed care plan requires enrollees to designate a primary care provider, the plan must notify each enrollee who designated the terminating provider of the termination the greater of 30 days prior to the termination of 15 days following the insurer's receipt of the provider's termination notice.

Recommended Change: Eliminate the 15-day provision and require health plans to provide notice 30 days prior to the termination.

Rationale: We recognize the need to notify enrollees of the termination of their primary provider. However, the "greater of" language in the rule creates an interesting problem.. A provider may notify a plan of his intentions to terminate as much as 180 days from the effective date of that termination. Oftentimes health plans negotiate with these health care providers after a termination notice has been submitted and ultimately the provider does not terminate his/her contract. Under the rule, health plans would have to notify an enrollee within 15 days of receipt of a provider's notice to terminate yet the provider might not actually terminate. This situation can cause undo panic and anxiety for our members. Members may change providers because of the notice only to find later that the provider continues to participate. Plans would also have to incur that added expense of sending a second notice informing members that the provider is continuing in the plan's network. Limiting the notice to 30 days allows the health plan to require substantial advance notice in order to continue to negotiate with health care providers and avoid a service disruption. Thirty days still provides adequate notice to enrollees.

INS 9.37 (2) Notice Requirements

Current Language: Managed care plans shall mail or deliver current provider directories to enrollees upon enrollment, and no less than annually, following the first year of enrollment.

Recommended Change: Managed care plans shall make current provider directories available to enrollees upon open enrollment, and no less than annually, following the first year of enrollment.

Rationale: Our current practice is to provide information regarding the network in two basic ways: printed directories and a toll free provider verification number. We currently distribute these directories at open enrollment through the participating employer and at other times upon request. It takes about two printed directories per subscribers under this system. Based on our experience with the state employee health plan, which does require directories are mailed to each subscriber annually, we would have to print 40 percent more directories. Humana estimates that **this requirement including postage and printing will add $258,000 in costs annually**. At the same time, a member can turn their identification card over and find a toll-free number that will provide them with up-to-date information and verification of the health care providers that are available within our plans network. We believe the requirement to mail or deliver adds unnecessary administrative expense and should be eliminated.

Thank you for your consideration of these changes. If you have questions, please feel free to contact Humana representatives: Allan Patek (920-337-5618), Andrea Dilweg (920-337-5553), or Ann Jabloski (608-251-0702).

Humana is one of largest health insurer providers in the state providing HMO, PPO, POS and managed indemnity coverage as well as self-fund plan administration to more than 500,000 state residents. Humana's health plans include Humana/WHO, Emphyses Wisconsin, and Employers Health Insurance

DELTA DENTAL
Delta Dental Plan of Wisconsin

Faxed transmission, one page only

October 13, 1999

Dennis L. Brown
President

2801 Hoover Road
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Senator Rodney Moen
Chairman, Senate Committee on Health
State Capitol
Madison, Wisconsin

RE: Managed Care Rule

Dear Senator Moen:

We wish to be on record with your committee as being opposed to the Managed Care Rule as presently drafted.

Delta Dental Plan of Wisconsin is a monoline insurance carrier, providing only limited scope dental benefits. With agreement by the OCI to a two-word insertion for clarification, we were exempt from this Rule. However, a redraft inadvertently reversed this. A request to OCI for another language correction has been made but not yet acted upon. We feel that the proposed sec. Ins. 9.42 is confusing in that we are exempt under the definition of health benefit plans which would include managed care plans, but included as a preferred provider plan. In dental there are numerous alternate treatments for a condition. We do not manage care in that providers and patients are always free to pursue elective courses of treatment. By contract, our only variance may be in applying the cost of a lesser expensive alternate to the course of treatment elected by the patient. Compliance with the Managed Care Rule would be impractical, expensive, and yield no material benefit or protection under a dental policy which an enrollee does not already enjoy.

Thank you for your consideration of our position.

Sincerely,

Dennis L. Brown
President

DLB/jmg

Midwest Security
INSURANCE COMPANIES

Carol A. Trocinski, HIA
PARALEGAL
COMPLIANCE ADMINISTRATOR

2700 MIDWEST DRIVE, ONALASKA WI 54650-8764

608-783-8554 OR 800-542-6642
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Midwest Security
INSURANCE COMPANIES

SEP 22 1999

September 21, 1999

via fax 608-267-2871

The Honorable Rodney Moen
Room 8 South, State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Re: OCI Managed Care Rule

Dear Senator Moen:

This letter is written on behalf of Midwest Security Life Insurance Company (Midwest), a life and health insurance company domiciled in Wisconsin.

Midwest is primarily an insurer of small employer groups in the State of Wisconsin. Over 60% of the health policies we issue are in this state. As an insurance company, we are committed and dedicated to the improvement of our products and services to meet the needs of our insureds. Midwest feels that the proposed managed care rule treats all managed care plans similar. The managed care business that we market is primarily through leased networks that we contract with in order to receive a discounted rate. These networks contract separately with the providers and facilities. If the insured goes to an in-network provider, benefits are covered at a higher benefit level. If the insured chooses to go to an out-of-network provider, insured claims are still paid, however at a lower benefit level. Midwest does not control the care; instead we offer a financial incentive for an insured to be treated by an in-network provider.

Preferred Provider Plans (PPO) are usually less expensive for insureds versus traditional indemnity plans. PPO plans usually provide a larger discount on claims for providers who have contracted with the PPO network. In order for PPO plans to survive in the marketplace, the costs of additional compliance will be passed onto insureds through increased premiums. Insurers may be unable to continue to market PPO business in the State of Wisconsin due to the inability to comply with the extensive reporting requirements as are proposed.

Since the first draft of the managed care rule, Midwest has met with the staff at OCI on several occasions to express our concerns with the proposed rule. The rule has been revised to create exemptions for health insurance plans that engage in a limited amount of managed care activities. After reviewing the exemption under INS 9.32, Midwest would be challenged to meet all the requirements listed as currently drafted. Attached are modifications to 3 key areas of the rule that we ask you to review.

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A summary of Midwest's issues are as follows: (1) Access to information required by the proposed rule is not always available through leased networks. (2) PPO plans generally have very limited managed care activities. The exemption under INS 9.32 should be expanded to include these types of plans. (3) The focus of the rule should be geared toward HMO plans not small group health insurers. Whereas HMO plans generally pay only those claims if the insured receives treatment by a HMO provider, PPO plans pay claims for treatment received by in-network and out-of-network providers. (4) Health insurance options available to employers may become limited and more expensive.

We understand the need for managed care plans to be regulated, however, we ask that you recognize the differences which exist within these plans and not adopt rules which subject all managed care plans to the same requirements.

Thank you in advance for your time on this issue. Should you have any questions, please feel free to contact me at 608/783-8554.

Sincerely,

Carol A. Trocinski

Carol A. Trocinski
Compliance Administrator

Enclosures

Chapter Ins. 9 – Managed Care Plans Proposed Regulations Recommended Amendments

Submitted By: Midwest Security Life Insurance Company

INS 9.32(4) - Exemption

Issue: The current exemption criteria are too limited and will not include those health insurance plans that perform a limited amount of managed care activities.

Recommendation: Either delete (4) or revise to state "The plan's only financial incentive to the insureds is a co-insurance differential of not more than 30% between in-plan versus off-plan providers".

INS 9.37(2) – Notice Requirements

Issue: Annual mailing of provider directories to each enrollee is a very manual and expensive process.

Recommendations: (2) Managed care plans shall make current provider directories available to enrollees upon enrollment, and a toll free number for enrollees to request current provider directories/information at all other times.

INS 9.40 – Required Quality Assurance Plans

Issue: Managed care plans are to begin submitting HEDIS or a similar standardized data set to the commissioner beginning April 1, 2001. HEDIS standards include data sets that most insurers in Wisconsin do not capture. Insurers and their vendors will be required to invest in new systems to meet this requirement. It is estimated that a HEDIS type system could cost up to one-million dollars. This would not include the administrative costs related to the collection of data, support and maintenance of the system or the compilation and generation of the reports on an annual basis. The Office of the Commissioner is encouraged to take into consideration the time necessary to develop a meaningful data set and work with industry representatives to create a meaningful consumer report.

Recommendation: (3) Beginning April 1, 2002, every managed care plan, limited service health organization and preferred provider plan shall submit ~~its HEDIS data, or other~~ standardized data set designated by the commissioner, for the previous calendar year to the commissioner no later than April 1 of each year. No later than July 1 of each year, the commissioner shall prepare a summary report on the collected data.

BlueCross & BlueShield
United of Wisconsin

An independent licensee of the Blue
Cross and Blue Shield Association

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TESTIMONY ON CR-98-183
(The Managed Care Rule)

Presented by Blue Cross & Blue Shield United of WI
September 14, 1999

Good morning Chairman Underheim and members of the committee. Thank you for providing us with the opportunity to testify today on CR 98-183 (the managed care rule.) Blue Cross & Blue Shield and our family of companies have expressed support for managed care reforms since the beginning of this process. We have been and continue to be cognizant of our need to put forth continuous and diligent efforts to modify and revise our procedures to assure that we exceed the expectations of an increasingly informed constituency.

MEDICARE + CHOICE

Specifically, we would like to address three areas of the rule. First, the Medicare + Choice provisions. Clearly, the Medicare + Choice regulations are governed by the federal government. The Health Care Financing Administration (HCFA) regulations specifically preempt state law in three areas of Medicare + Choice regulation:

- benefit requirements
- inclusion of providers
- coverage determinations (including related grievance processes.)

In a recent Milwaukee Journal Sentinel article, OCI acknowledged the preemption issues but still maintained that some areas of the regulations fall under their purview. In order for a Medicare + Choice organization to effectively operate in this highly regulated industry, it is imperative that we are not left to guess which regulations OCI will choose to enforce. OCI's interpretation of the rules could result in imposing more stringent requirements on Wisconsin Medicare + Choice organizations than on

organizations operating in other states. (Wisconsin already operates at a disadvantage in the Medicare reimbursement formulas compared to other states. We do not need further impediments.)
If the final regulations purport to govern Medicare + Choice products, then OCI should clearly delineate which provisions they feel are preempted by federal law and those they plan to govern.

CONTINUITY OF CARE

The fact that the current rule does not provide an exception to the continuity of care provisions, even if the provider has been terminated from our network due to failure to meet our credentialing standards, is of great concern to BCBSUW.

Managed care organizations have developed robust processes for systematically reviewing providers credentials against well established predetermined quality criteria, interpretation by clinicians from our local practicing community and allowing for due process for reconsideration. If those conditions have been met, plans should be allowed to take action to promptly remove providers from the network. We believe these are credentialing guidelines aligned in the patient's best interest. Failure to take immediate action after this robust and deliberate quality process is contrary to our mutual interst to protect our citizens from practitioners that do not meet our high standards of participation. To increasingly hold managed care organizations to accountability for quality, and customer satisfactions while at the same time tying their hands around one of their most effective tools to improve those aspects is at cross purposes.

The rule before the committee also contains some requirements relating to provider directories which involve unnecessary, substantial cost. The rule requires a managed care plan to issue new provider directories each year to each enrollee. Currently, our companies provide each employer group with a supply of new directories each year which are available to employees **upon request**. This new requirement will cost our companies over $400,000 per year. This rule unnecessarily diverts substantial dollars away from patient care.

HEDIS DATA SUBMISSION

Finally, BCBSUW urges OCI to adopt HEDIS data as the required submission data and to not designate or require any other standardized data set. Through HEDIS standards we can have a system of efficient reporting as well as data that is useful for true valid comparison and benchmarking. It is in our collective best interest to avoid redundancy by requiring any other data set reporting. *

Thank you again for providing this opportunity to testify before your committee today. We would be happy to entertain questions.

* where we are coming from on this is that many of us who have both managed care products & indemnity + PPO products feel that NEIDIS data submission serves as a reasonable reporting mechanism. We simply don't want to have to provide two different sets of data; one in NEIDIS Form & 2 - created by OCI -

Please call with any questions.

COLLABORATION FOR HEALTHCARE CONSUMER PROTECTION

TESTIMONY BEFORE THE ASSEMBLY HEALTH COMMITTEE ON FINAL DRAFT OF MANAGED CARE CONSUMER PROECTION RULES

SEPTEMBER 14, 1999

COLLABORATION MEMBERS

Center for Public Representation
Medical Society of Milwaukee County
Wisconsin Society for Podiatric Medicine
AARP - Wisconsin
State Medical Society of Wisconsin
Wi. Nurses Associ

Collaboration on Healthcare Consumer Protection
Summary of Comments
Assembly Health Committee
September 14, 1999

- Support the broad definition of "managed care" in § 9.01 (12) that includes Medicare + Choice and Medicare Select plans and less stringent managed care plans.

- Support the exemption continuum in § 9.32. However, we have some reservations about sub. (5). We feel this weakens efforts to improve quality assurance in health insurance plans.

- Support the inclusion of relationships between the plans and their providers in the HMO business plans that are to be submitted to the OCI in § 9.05. Also support requirement that provider agreements that contain specified clauses be included in the business plan.

- Support the described grievance procedure process in §9.33 with one strong exception. CHCP feels that under no circumstances should the enrollee member of a grievance panel be an employee of the plan.

- Support the application of the grievance procedure process broadly across all managed care plans. We are pleased that it is not subject to exemption under § 9.32.

Collaboration on Healthcare Consumer Protection
Testimony
Assembly Health Committee
September 14, 1999

The Collaboration on Healthcare Consumer protection is generally pleased with the managed care consumer protection administrative rules as submitted to the legislature. We do have several comments to share, as follows:

Managed Care Definition

"Managed care plan" is defined broadly in Wisconsin Administrative Code § 9.01 (12). This broad definition encompasses "managed care" under § 609.01 (3)(c) Wis. Stat., Medicare+ Choice, Medicare Select, and health benefit plans that directly or indirectly contract with providers.

The CHCP favors this board definition that will place the vast majority of health delivery insurance organizations under the proposed managed care rules. First, as discussed below, Medicare plans should be subject to state regulation. Second, less stringent managed care plans, such as PPOs, should fall under the proposed rules as well. In these instances, the insured still needs adequate protection from the insurer due to factors including inequality in bargaining power, (potential) insured lack of information regarding quality, and general adverse incentives between the insured and insurer.

Note that the "standard plan" as defined in § 609.01 (7) Wis. Stat. is not included within this broad definition. Many of the adverse incentives present in managed care are not found in the traditional fee-for-service medicine, which presently describes only a small percentage of plans underwritten.

Exemption Continuum

Wisconsin Administrative Code INS §9.32 provides a continuum for exemptions. This item has been added subsequent to the April 19, 1999 draft.

CHCP supports this continuum. Exemptions provided include: quality assurance under § 609.32 Wis. Stat., providing a medical director under § 609.34 Wis. Stat., additional access standard requirements under Wisconsin Administrative Code INS § 9.34 (2) (a) and (b), required quality assurance plans relating to § 609.32 Wis. Stat. under Wisconsin Administrative Code INS § 9.40, and access and record keeping requirements under Wisconsin Administrative Code INS § 9.42.

In order to qualify for these exemptions, the proposed rules extract conditions related to access and provider composition that have some of the same substantive content as the exempted provisions.

The most important of these conditions are Wisconsin Administrative Code INS § 9.32 (4) and (5). Under sub. (4), co-payment differentials between in-plan versus out-of-plan providers are limited to 10%. This has the benefit of allowing the consumer/insured essentially free choice of providers by reducing the costs associated with choice. Since choice is increased, quality and access exemptions logically follow. The consumer/insured dictates these outcomes as a function of their choices. A concern with allowing too much choice; is that consumers/insureds will make inefficient decisions, since they are not spending their own money. The freedom of choice benefit outweighs possible inefficiency concerns which will be presumably reflected in higher premiums. Additionally, note that this is only a condition necessary to opt into the Wisconsin Administrative Code INS § 9.32 exemption scheme and is not mandatory.

Under sub. (5), the plans cannot make "representations regarding quality of care." CHCP supports this subsection with reservation. We don't believe that OCI should encourage any type of plan that does not strive to improve and maintain high quality care.

Finally, and very importantly, note that the grievance procedure is not exempted by the provision. Wisconsin Administrative Code § 9.33 remains in place regardless.

State Control Over Medicare Plans

The CHCP supports state control over Medicare + Choice and Medicare Select plans in addition to federal control.

More protection for the consumer is the goal of subjecting Medicare HMOs to state control. The state control will supplement federal control and improve overall consumer protection. The greater level of protection justifies the minimal cost possibly incurred by consumer via increased premiums.

Availability of Contracts

Pursuant to Wisconsin Administrative Code INS § 9.05 (1)(a), the relationship with providers, whether salaried employees, group contractors or individual contractors is required to be provided in the business plan for health maintenance organization insurers as part of their application for a certificate of incorporation and certificate of authority. Under sub. (4), provider agreements that contain specified conflicts of interest, including risk shifting to providers, will be included within the business plan.

Copies of provider agreements are made available to the Commissioner of Insurance under Wisconsin Administrative Code INS § 9.07 (1). Consumers

may obtain the information under INS § 6.13, an open records provision, that has certain limitations.

Grievance

Wisconsin Administrative Code § 9.33 provides grievance procedures. INS § 9.01 (5) broadly defines grievance. CHCP supports the procedural scheme set forth with one important exception. CHCP strongly feels that under no circumstances should the enrollee member of a grievance panel be an employee of the plan. This would introduce an overwhelming conflict of interest on the part of the enrollee panel member and undercut the validity of the grievance process.

CHCP is very pleased that the grievance procedures are applicable across the board and not subject to exemption under Wisconsin Administrative Code § 9.32.

Availability of Information

CHCP supports the policy of information dissemination to consumers. Information aids in rational and efficient choices by consumers among competing health plans. Pursuant to Wisconsin Administrative code INS § 9.33 (7)(c) and (d) grievance information is provided to the Commissioner of Insurance. Wisconsin Administrative Code INS § 6.13 provides this information to the consumer as part of open records.

Wording Issue

Does not the Wisconsin Administrative Code INS § 9.07(1) mean to say "withhold from requester" rather than from the "insurer"?

BlueCross & BlueShield
United of Wisconsin

An independent licensee of the Blue
Cross and Blue Shield Association

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TESTIMONY ON CR-98-183
(The Managed Care Rule)

Presented by Blue Cross & Blue Shield United of WI
September 14, 1999

Good morning Chairman Underheim and members of the committee. Thank you for providing us with the opportunity to testify today on CR 98-183 (the managed care rule.) Blue Cross & Blue Shield and our family of companies have expressed support for managed care reforms since the beginning of this process. We have been and continue to be cognizant of our need to put forth continuous and diligent efforts to modify and revise our procedures to assure that we exceed the expectations of an increasingly informed constituency.

MEDICARE + CHOICE

Specifically, we would like to address three areas of the rule. First, the Medicare + Choice provisions. Clearly, the Medicare + Choice regulations are governed by the federal government. The Health Care Financing Administration (HCFA) regulations specifically preempt state law in three areas of Medicare + Choice regulation:

- benefit requirements
- inclusion of providers
- coverage determinations (including related grievance processes.)

In a recent Milwaukee Journal Sentinel article, OCI acknowledged the preemption issues but still maintained that some areas of the regulations fall under their purview. In order for a Medicare + Choice organization to effectively operate in this highly regulated industry, it is imperative that we are not left to guess which regulations OCI will choose to enforce. OCI's interpretation of the rules could result in imposing more stringent requirements on Wisconsin Medicare + Choice organizations than on

organizations operating in other states. (Wisconsin already operates at a disadvantage in the Medicare reimbursement formulas compared to other states. We do not need further impediments.)
If the final regulations purport to govern Medicare + Choice products, then OCI should clearly delineate which provisions they feel are preempted by federal law and those they plan to govern.

CONTINUITY OF CARE

The fact that the current rule does not provide an exception to the continuity of care provisions, even if the provider has been terminated from our network due to failure to meet our credentialing standards, is of great concern to BCBSUW.

Managed care organizations have developed robust processes for systematically reviewing providers credentials against well established predetermined quality criteria, interpretation by clinicians from our local practicing community and allowing for due process for reconsideration. If those conditions have been met, plans should be allowed to take action to promptly remove providers from the network. We believe these are credentialing guidelines aligned in the patient's best interest. Failure to take immediate action after this robust and deliberate quality process is contrary to our mutual interst to protect our citizens from practitioners that do not meet our high standards of participation. To increasingly hold managed care organizations to accountability for quality, and customer satisfactions while at the same time tying their hands around one of their most effective tools to improve those aspects is at cross purposes.

The rule before the committee also contains some requirements relating to provider directories which involve unnecessary, substantial cost. The rule requires a managed care plan to issue new provider directories each year to each enrollee. Currently, our companies provide each employer group with a supply of new directories each year which are available to employees **upon request**. This new requirement will cost our companies over $400,000 per year. This rule unnecessarily diverts substantial dollars away from patient care.

HEDIS DATA SUBMISSION

Finally, BCBSUW urges OCI to adopt HEDIS data as the required submission data and to not designate or require any other standardized data set. Through HEDIS standards we can have a system of efficient reporting as well as data that is useful for true valid comparison and benchmarking. It is in our collective best interest to avoid redundancy by requiring any other data set reporting.

Thank you again for providing this opportunity to testify before your committee today. We would be happy to entertain questions.

Wisconsin Automobile & Truck Dealers Association

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Madison, WI 53703
(608) 251-5577 FAX: 251-4379

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P.O. Box 5345, Madison, WI 53705-0345

GARY D. WILLIAMS
President

TO: Wisconsin Assembly Committee on Health

FROM: Wisconsin Automobile and Truck Dealers Association

DATE: September 14, 1999

RE: OPPOSITION TO CLEARINGHOUSE RULE 98-183

The Wisconsin Automobile and Truck Dealers Association currently provides health insurance coverage to approximately 12,000 Wisconsin citizens statewide. Our members have the freedom to choose their own providers. Our insurance plan uses preferred provider organizations to pass discounts through to our members, and this enables our members to receive flexibility in choosing a health care provider at a reasonable cost.

We oppose the proposed rule change because our plan could not operate under the changes. As drafted, it would not allow us to collect the necessary data to meet the reporting requirements and our 12,000 participants would be forced to find other health insurance coverage that will probably be more restrictive and costly.

September 15, 1999

TO: Assembly Health Committee

FROM: Tim Hartin, General Counsel

SUBJECT: INS 9 – Patient Protection Act Rules

We would like to request a single change to the INS rules discussed in such detail at yesterday's Assembly Health Committee hearing.

The patient protection statute requires that, subject to certain time limits, a managed care plan must provide coverage for any provider (including a hospital) that was listed in the plan's marketing materials as a participating provider, even after that provider's participation in the plan has terminated.[1] As a general rule, the statute requires coverage of providers listed in marketing materials distributed during the last open enrollment period, or to the enrollee in question during their enrollment. Different coverage periods are provided for primary care physicians[2] and ongoing courses of treatment.[3]

The statute goes on to provide that the provider shall be reimbursed at his or her "most recent contracted rate" for services rendered under these continuity of care provisions, unless their contract specifically addresses such services.[4]

Taken as a whole, these provisions would seem to allow a managed care plan to "lock in" a provider at contract rates even after termination of their contract. These contract rates give the managed care plan the benefit of discounts.

The continuity of care provisions appear to impose a mandate on managed care plans, not providers. However, these provisions also extend the "hold harmless" provisions prohibiting providers from collecting any shortfalls from managed care patients to cover providers in a continuity of care situation.[5]

This means that providers could be locked into their last contract rate with a managed care plan, with no legal recourse or ability to renegotiate that

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[1] § 609.24(1)(a) Wis. Stats.
[2] § 609.24(1)(b) Wis. Stats.
[3] § 609.24(1)(c) Wis. Stats.
[4] § 609.24(1)(e)(2) Wis. Stats.
[5] § 609.24(3) Wis. Stats.

rate. Clearly, such a result was not intended by the legislature, and is not desirable from the perspectives of policy or fairness.

To help prevent rate lock-in, we suggest that the following language be added as INS 9.34(1)(c):

> "A managed care plan that fails to provide notice as required by 9.34(1) shall, at the request of the affected provider, pay that provider the provider's usual and customary charges for services rendered to plan enrollees after the effective date of that provider's termination of participation in the plan."

This provision states that, in order to take advantage of the provision giving them the contract discount rates after termination of the contract, managed care plans must comply with the provisions governing prompt notification of affected patients. We think it is only fair that a managed care plan seeking to take advantage of one regulatory provision, to its profit, should be required to comply with other related provisions.

Thank you for consideration of this issue. Please call me at 608/274-1820 or email at thartin@wha.org if you wish to discuss this issue further.

18 COPIES

American Family proposed revisions to CR98-183

AMEND INS 9.32 (p.15) AS FOLLOWS:

(2) The plan demonstrates, by certification, that it provides adequate access to providers in accordance with s.609.22, Stats., and s. Ins 9.34(1), or the plan offers prospective enrollees the option of adding network provider coverage at no additional cost and discloses the names, addresses and specialties of participating providers at the time of sale.

(3) The plan has sufficient number and type of plan providers to adequately deliver all covered services based on the demographics and health status of current and expected enrollees served by the plan, or the plan provides coverage at the in-plan reimbursement rate for services rendered by off-plan providers, including pathologists, radiologists, anesthesiologists, and emergency medicine physicians when the plan has no in-plan providers of the same specialty under contract, or the plan offers prospective enrollees the option of adding network provider coverage at no additional cost and discloses the names, addresses and specialties of participating providers at the time of sale.

GROUP HEALTH

COOPERATIVE OF EAU CLAIRE

Testimony Presented
To The
Assembly Committee On Health
Regarding CR 98-183, Managed Care Regulation
By
Peter C. Farrow
Chief Operating Officer,
Group Health Cooperative of Eau Claire
September 14, 1999

Thank you Chairperson Underheim and members of the Committee for the opportunity to present testimony related to the administrative rules implementing sections of the managed care laws passed in 1998. In addition to my role at Group Health Cooperative, I am here as a member of the Association of Wisconsin HMOs.

Many of you may recall that when this law was drafted and passed, I was serving as the Assistant Deputy Insurance Commissioner. In that role, I assisted in drafting and negotiating the requirements written into the law. At the time, the goal of the legislation was to enact meaningful protections for health insurance consumers without unnecessarily adding to administrative requirements or significantly increasing costs. Both Sen. Roessler and Rep. Ladwig, the lead authors of the requirements, worked hard to accomplish those goals.

I also want to recognize Commissioner O'Connell and her staff for the lengthy efforts they have undertaken to prepare this rule.

Before commenting on specific areas, I would like to offer some perspective on this area of regulation. Small non-profit plans, like Group Health, and large stock insurers pose different regulatory challenges, and at times require a different regulatory approach.

Both structures have proven able to provide quality coverage to their enrollees, and play a key role in a competitive marketplace. Historically, the strength of Wisconsin's insurance statutes and regulation has been the recognition of the need for that kind of flexibility.

As you have all heard recently, health care costs are again increasing at double-digit rates. Drug costs are currently increasing at a rate of twenty percent a year, and professional services and hospital costs are combining for increases between 10 and 20 percent for insurers. Employers continually pressure insurers to keep insurance premiums down, resulting in premiums that have failed to keep up with the costs of covering the care provided. In this environment it is as important as ever that regulations not add unnecessary cost.

My testimony focuses on a few issues remaining in the rule that are either unclear, or run counter to accomplishing the goal of improving consumer protection without unnecessarily adding administrative burden or increasing costs.

Grievances:

Page 16 - INS 9.33 (1) (a) contains a requirement that was added in the latest draft to require that "The insurer shall provide notice within each policy and certificate issued to enrollees describing that if a provider denies a request for a referral from an enrollee, the enrollee has a right to additionally request the referral from the insurer." By requiring insures to approve referrals that have been denied by a provider, the rule weakens, rather than reinforces the role of an enrollee's physician in determining the appropriateness of care. This sentence should be deleted.

Page 17 – INS 9.33 (5) (d) establishes standards for the composition of an insurer's grievance committee. This section limits who can serve on the panel, and attempts to state that if a panel contains at least three persons, one of those people may be a

subordinate of the person who ultimately denied the initial coverage request. The sentence reads, "The panel may include no more than 1 of the person or persons' subordinates only if the panel consists of at least three persons." Interpreted literally the sentence would allow a grievance panel of two members who are both subordinates of the decision maker. This sentence should at least be redrafted.

For small plans, this type of restriction poses significant issues. For example, because of its size Group Health does not have a large utilization review staff, precluding the initial decision maker from the grievance committee dramatically reduces the chances to have a health care professional serve on the committee. It also presupposes that given new information, a health care provider, such as a physician medical director, would not change their mind. A review of current grievances, most of which were heard by committees containing a medical director, would show this concern is not a real problem.

Continuity of Care:

Page 19-20 – INS 9.35 (1) (a-c) are sections that have been significantly redrafted in the most recent draft. The language in the new draft is less clear than the previous draft. In addition, paragraph c requires insurer contracts with providers to contain language requiring providers post notices to patients if they terminate a relationship with an insurer. The likelihood of providers widely agreeing to this language is about as limited as the chance providers would actually post such a notice for at least 30 days. The previous draft contained more appropriate language.

Page 20 – INS 9.35 (2) (b) allows an exemption from continuity of care if a provider is terminated for professional misconduct. The standard set in the statute references only "misconduct". The rule should be amended to reflect the language in the statute. In addition, this language should be in some way reflect the quality assurance requirements in s. 609.32 (b) Wis. Stats. This language requires plans to regularly review the quality of care delivered by contracted providers. Without a link between these statutes, plans

will be required to offer continuity of care for providers they are terminating due to poor quality of care. In other words, the rule will require coverage of less than acceptable quality of care – exactly counter to the goals of this law.

Notifications – Provider Directories

Page 20 – INS 9.37 (2) requires insurers to "mail or deliver" provider directories no less than annually to enrollees, language again new in the most recent draft. Prior drafts contained that required insurers to "make current provider directories available" no less than annually.

Health information is regularly cited as one of the most frequent uses of the Internet. By requiring delivery, the rule ignores other forms of providing current directories, such as websites. The preferable language from the previous draft would require insurers to regularly provide enough directories to employers to meet enrollee requests without adding the cost of printing a directory for every enrollee. The annual cost of printing and mailing directories to all managed care enrollees would add millions of dollars to administrative costs and not add significantly to the level of care provided.

The managed care laws better addressed the concern of making sure enrollees have up to date information by requiring insurers to cover the providers represented in marketing materials as part of their network at the time of enrollment. In other words, the insurer is on the hook if they provide up-to-date information. The continuity of care language that contains this provision is among the most pro-consumer language of its type in the country.

Every one of these changes centers on language that is unclear, or on areas where previously drafted language was preferable. All of them focus on controlling unnecessary costs and administrative burdens. Thank you for allowing me the time to present these comments. I'd be happy to answer any questions you may have.

DRAFT

American Family Testimony on
OCI Managed Care Rule
September 14, 1999

GOOD MORNING. MY NAME IS LEE FANSHAW AND I AM GOVERNMENT AFFAIRS COUNSEL FOR AMERICAN FAMILY INSURANCE. WITH ME TODAY IS DAVE PETERS, SR. STAFF UNDERWRITING ANALYST FOR OUR LIFE AND HEALTH COMPANY. AMERICAN FAMILY IS A MULTILINE INSURER HEADQUARTERED IN MADISON, WISCONSIN. WE HAVE APPROXIMATELY 7000 EMPLOYEES (OVER HALF IN WISCONSIN) AND ABOUT 4000 AGENTS.

ALTHOUGH OUR PRIMARY BUSINESS IS PROPERTY AND CASUALTY INSURANCE SUCH AS AUTO AND HOMEOWNERS, WE ALSO SELL INDIVIDUAL HEALTH INS. WE PRESENTLY HAVE ABOUT 28,000 HEALTH POLICIES IN FORCE IN WIS., COVERING APPROXIMATELY 50,000 LIVES.

I APPEAR BEFORE YOU TODAY TO SEEK YOUR HELP IN OBTAINING MODIFICATIONS TO THE PROPOSED RULE.

BY WAY OF BACKGROUND, MOST OF OUR POLICYHOLDERS SEEK COVERAGE FROM US BECAUSE THEY LACK ACCESS TO TRADITIONAL GROUP OR HMO-TYPE COVERAGE. THIS IS AN IMPORTANT SEGMENT OF THE MARKET THAT OFTEN HAS DIFFICULTY FINDING AFFORDABLE COVERAGE. OUR PLAN ALLOWS OUR INSUREDS TO SEEK MEDICAL TREATMENT FROM THE PROVIDER OF THEIR CHOICE, WITH BENEFITS REIMBURSED ON AN 80/20 BASIS.

IN AN EFFORT TO HOLD DOWN PREMIUM COSTS FOR OUR POLICYHOLDERS, WE ALSO ~~OFFER~~ AUTOMATICALLY PROVIDE A **NO-COST** PPO RIDER. HERE'S HOW IT WORKS: OUR INSUREDS RECEIVE A DIRECTORY OF PARTICIPATING PROVIDERS IN WISCONSIN ONCE A YEAR. MEDICAL SERVICES FROM THOSE PROVIDERS ARE REIMBURSED ON A 90/10 BASIS. THIS ARRANGEMENT BENEFITS THE POLICYHOLDER IN TWO WAYS. THOSE WHO UTILIZE PPO PROVIDERS PAY LESS ON THEIR CO-PAY. IN ADDITION, BECAUSE THE COMPANY RECEIVES DISCOUNTS ON SERVICES FROM THESE PROVIDERS, ALL POLICYHOLDERS BENEFIT IN THE FORM OF LOWER PREMIUMS THAN THEY WOULD OTHERWISE PAY IF WE HAD NO PPO ARRANGEMENT. UNFORTUNATELY, IT IS THE USE OF THE PPO RIDER THAT ENTANGLES US IN THE WEB OF THE 32-PAGE RULE BEFORE YOU TODAY.

SINCE THE FIRST DRAFT OF THIS RULE, WE'VE MET ON SEVERAL OCCASIONS WITH THE STAFF AT OCI TO EXPRESS OUR CONCERN ABOUT THE SCOPE OF THE RULE AND THE DIFFICULTIES IT WOULD CREATE FOR INDEMNITY INSURANCE PLANS LIKE OURS. WE'VE EXPLAINED TO THE DEPT. THAT FULL COMPLIANCE WITH THE RULE WILL BE BURDENSOME AND EXPENSIVE AND THAT IT WILL RESULT IN SUBSTANTIAL PREMIUM INCREASES FOR OUR WISCONSIN POLICY-HOLDERS.

AT A MEETING LAST MAY, THE DEPARTMENT RECOGNIZED OUR CONCERNS AND INDICATED THAT THE RULE WOULD BE MODIFIED TO CREATE ADDITIONAL EXEMPTIONS FOR INDEMNITY HEALTH PLANS LIKE OURS. IT APPEARS THAT THE DEPARTMENT MADE A GOOD FAITH EFFORT TO CREATE AN EXEMPTION ALONG THESE LINES IN SECTION 9.32 OF THE RULE (ON PAGE 15), BUT UNFORTUNATELY, OUR READING OF THAT SECTION SHOWS THAT WE WOULD BE UNABLE TO MEET ALL THE CRITERIA LISTED AND THUS WE WOULD STILL BE FORCED TO COMPLY WITH EVERY ASPECT OF THE RULE.

YOU MAY HEAR THE ARGUMENT THAT WE CAN COMPLY WITH THE RULE BY LIMITING THE GEOGRAPHIC SCOPE OF OUR PPO TO CERTAIN REGIONS OF THE STATE. THIS WOULD BE DIFFICULT FOR US OPERATIONALLY, BUT MORE IMPORTANTLY WOULD CREATE PROBLEMS FOR SOME OF OUR INSUREDS WHO MIGHT LIVE IN A NON-PPO AREA, BUT WHO MIGHT ROUTINELY DRIVE TO A LARGER CITY (e.g. RHINELANDER – WAUSAU) TO RECEIVE MEDICAL CARE.

THE USE OF OUR PPO NETWORK IS CLEARLY BENEFICIAL TO ALL OF OUR WISCONSIN POLICYHOLDERS. WE ESTIMATE THAT OUR SAVINGS IN 1999 WILL BE AT LEAST $2 MILLION. IF THIS RULE GOES INTO EFFECT WITHOUT MODIFICATION, WE WILL GIVE SERIOUS CONSIDERATION TO DISCONTINUING USE OF THE PPO. THIS WILL RESULT IN PREMIUM INCREASES FOR ALL OF OUR WISCONSIN POLICYHOLDERS.

WE UNDERSTAND THE DESIRE ON THE PART OF THE LEGISLATURE AND THE DEPARTMENT TO PLACE NEW CONTROLS ON MANAGED CARE. WE DO NOT BELIEVE IT WAS THE LEGISLATURE'S INTENT TO DRIVE UP THE COST OF HEALTH INSURANCE FOR INDIVIDUALS WHO PURCHASE INDEMNITY INSURANCE PLANSS. WE HAVE DRAFTED SOME SUGGESTED MODIFICATIONS TO THE RULE WHICH WE WILL SUBMIT TO THE COMMITTEE FOR CONSIDERATION.

THANK YOU FOR YOUR TIME TODAY. DAVE PETERS AND I WOULD BE HAPPY TO RESPOND TO ANY QUESTIONS YOU MIGHT HAVE.

TESTIMONY BEFORE THE ASSEMBLY HEALTH COMMITTEE ON CR 98-183

September 14, 1999

Members of the Committee:

My name is Carol Rubin. I am appearing on behalf of the WEA Insurance Trust and its Insurance Corporation. Thank you for inviting me to speak to the Committee today.

The WEA Insurance Trust is a not-for-profit employee benefit trust established by the Wisconsin Education Association Council 29 years ago to provide members with viable alternatives to commercial insurance products. The Trust, through its wholly owned insurance corporation, provides group health insurance, as well as prescription drug, dental, long term disability, life, and long term care insurance to Wisconsin school district employees.

WEA Insurance currently provides group *health* coverage to 54,000 employees in 330 school districts all over Wisconsin, amounting to over 137,000 individuals in total. The volume of our annual health premium is $290 million. Over 99% of the school districts we insure choose to remain with us year after year. The impact of increased benefit costs on the salaries of school district employees is not a theoretical matter for us or those employees, and in response we have developed several alternatives to our traditional indemnity group health plan.

WEA Insurance has followed the development of these rules closely. Many of the rules' requirement are reasonable and truly consumer oriented. For example, all plans should be required to have effective, prompt grievance procedures, all plans should be clear about coverage limitations on experimental treatment. Plans should allow direct access to ob/gyns, and standing referrals, and plans should pay for second opinions. No plans should impose gag provisions on the providers associated with the plan. WEA Insurance has long conformed to these requirements voluntarily and welcome their application to other health plans.

However, in one key area, the draft rules require correction. In imposing specific, burdensome

quality assurance requirements not only on HMO's but also on indemnity plans which simply contract with a provider network in order to obtain fee discounts, the rules would impose very significant burdens, and at times impossible requirements, where no significant consumer purpose is served. The best way to avoid this result is to craft an exemption rule that allows more flexibility for discounted fee arrangements which do not attempt to manage care. Draft rule 9.32, the new exemption rule, clearly recognizes this need, but fails to achieve the necessary flexibility. I will focus the rest of my oral comments on the exemption rule.

Background

Let me briefly contrast a traditional indemnity plan with a plan that uses a fee discounted network. A traditional indemnity plan, also known as a "fee-for-service" plan, essentially reimburses a set percentage of each claim regardless of who provides the medical service. The most common reimbursement level is 80%, leaving the remaining 20% as coinsurance for the patient. While 80% is the norm, indemnity plans may reimburse at a 100% level, 90%, 70% or even 60%, with any remaining coinsurance being picked up by the insured individual. Even this co-insurance is usually capped by a stoploss amount of $1,000 or $2,000.

In an effort to manage the significant annual increases in medical costs, many indemnity insurers began to contract with specific networks of health care providers for fee discounts. These networks may offer a discount on their service charges of 2 %, 10%, 20% or more in exchange for an anticipated increase in the number of patients they will serve. The plan then encourages, but does not require, participants to use the network providers. For example, a plan that obtains a 20% discount from a network may reimburse services at 90% for members who use the network providers, but at 70% if participants ignore the network providers and seek care elsewhere. In effect, the plan is passing on the discount it receives from the network to its insured participants who use the network providers. The plan is not attempting to otherwise "manage the care" or significantly affect medical practice. It is only "managing the costs" of its plan.

A plan which simply negotiates a fee discount from a network and then reimburses at, for example, 100% for in-network services and 80% for out-of-network is conceptually no different from an indemnity plan that routinely pays only 80% of the cost of medical services--except that such a network plan is *more* generous than a traditional indemnity plan! If the worst economic penalty to an insured is that the plan will reimburse at 80%, rather than 90% or 100%, that is not a significant restriction on access to care. If an indemnity plan is always free to reimburse at 90% or 80% or 70% without regard to quality assurance, why should a network plan which does the same thing, but *in addition,* offers consumers an option for even higher reimbursement, be required to adhere to rigorous quality assurance standards when it is not managing quality of care?

The problem with OCI's draft exemption rule, Ins. 9.32:

The exemption drafted by OCI at Ins. 9.32 recognizes that plans which only contract for fee discounts and do not otherwise manage care should not be treated like true managed care plans. However, the rule as drafted has technical problems. The draft rule sets a minimum reimbursement level of 80% for *in-network* providers and then prohibits any reimbursement differential greater than 10% between in-network and out-of-network providers. The obvious result is that a plan may reimburse as little as 70% for out-of-network services, but then no more than 80% for in-network services. This is illogical and ignores real consumer interests. If a plan is able to negotiate a 15% or 20% or 22% discount from a network, why should the plan be prohibited from passing on that discount to those consumers who *choose* to use network providers and thus make the discount possible? If a plan wants to pay 100% for in-network services, and only 80% for out-of-network services, why should that be prohibited? (See the attached chart.)

There is a simple solution: revise the language of the exemption so that it simply sets a minimum acceptable threshold for reimbursement for *out-of-network* care, but does not include a 10% maximum reimbursement differential. OCI's rule implicitly recognizes that 70% reimbursement for out-of-network care is permissible and would not create a significant financial incentive; thus, that 70% minimum could be adopted outright. Or, since 80% reimbursement is such a common

reimbursement level for indemnity plans, the minimum reimbursement level for out of network services could be set at 80%. Once the minimum reimbursement level is set, plans should be free to set the reimbursement level for *in-network* services at 85% or 90% or 100%; the only real issue is whether the percentage of co-insurance imposed on the insured for out-of-network services is such that it truly prevents adequate freedom of choice. Obviously an 80% reimbursement level does not impose such a burden because it is a common reimbursement level even for traditional indemnity plans. In the alternative, the rule must allow for a reimbursement differential of at least 20%, rather than 10%.

Without adequate flexibility in this regard, plans will be unable to secure adequate fee discount arrangements, and consumers will be left with only two options: 1) very expensive indemnity plans such as those offered by the State of Wisconsin to its employees; and 2) HMO's.

Summary:

In summary, WEA Insurance believes that technical corrections should be made to Ins. 9.32, the exemption rule, by establishing a simple minimum co-insurance threshold such as 70% or 80% for out-of network services, and deleting any reference to the reimbursement differential between in-network and out-of network reimbursement. There is no significant reason to regulate the reimbursement rate of in-network services; doing so actually harms consumers since it means plans can only pass on a portion of the network discount the plan receives. The draft rule, without any direct benefit to consumers, would discourage if not destroy the development of less expensive alternatives to the traditional indemnity plan other than HMO's. Let us not forget that the traditional indemnity plan, while offering complete freedom of choice of providers, also led to a very significant increase in health care costs.

PAYMENT ALTERNATIVES FOR A

CLINIC PROCEDURE WITH CHARGE OF $300

Under Traditional Indemnity Plan	Under Plan With a Network Fee Discount
If 70%/30% reimbursement level: Individual pays $90	If 80%/70% differential per draft rules: Individual pays $60 in-network **or** Individual pays $90 out-of-network
	If 100%/80% differential: Individual pays $0 in-network **or** Individual pays $60 out-of-network
	If 90%/70% differential: Individual pays $30 in-network **or** Individual pays $90 out-of-network

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Clearinghouse Rule 98-138 – Managed Care Requirements

Comments to the Assembly Committee on Health

Submitted by: Humana

Humana has concerns with certain provisions in the current draft of Clearinghouse Rule 98-138. Humana supports the intent of the proposed rule and appreciates modifications that the department made through the course of its deliberations. However, we cannot support it in its current form and believe several significant issues need to be addressed.

Among the major changes we recommend are:

- **Limiting the application of the rule to only managed care plans;**
- **Providing notices to only those members affected by changes;**
- **Eliminating premature notices to members of provider terminations; and**
- **Eliminate the costly mailing of provider directories.**

Outlined below are our specific concerns and recommended changes.

INS 9.01 (12) Definition of "managed care plan"
Current Language: (12) "Managed care plan" has the meaning provided under s. 609.01 (3c), Stats., and includes Medicare Select policies as defined in s. 3.39 (30) (b) 4., and health benefit plans that either directly or indirectly contract for use of providers.

Recommended Change: (12) "Managed care plan" has the meaning provided under s. 609.01 (3c), Stats., and includes Medicare Select policies as defined in s. 3.39 (30) (b) 4., and health benefit plans *that vary covered services or cost sharing based on the use of specified providers.*

Rationale: Humana believes that the definition in the rule goes beyond legislative intent and does not address the concept of *incentives* that are used by a health benefit plan. The legislative intent was to apply the new standards established in Chapter 609 to health benefit plans that use differences in either benefits or cost sharing to *influence* a health plan members' choice of providers at or before the point of service. The definition of a managed care plan, health maintenance organization and preferred provider plans all recognize the use of incentives.

As written, all discounted fee arrangements between health plans and providers are subject to certain provisions of the rule including network adequacy and

continuity. Discounted fee arrangements are decidedly different than a plan's preferred provider or HMO network. Preferred networks are marketed to members as a key plan feature. Members are provided this preferred list of health care providers in advance of seeking service and benefit and cost sharing incentives steer the member to these preferred providers. We support requiring these regulations being applied to all network arrangements that conduct these activities consistent with the statutory definition of a managed care plan.

However, we believe applying the standards contained in Subchapter III of the rule to discounted fee arrangements exceeds the statutory authority and causes harm to consumers. Each year, we are able to save members money by accessing or negotiating situation discounts on provider charges. These fee discounts do benefit the consumer through reduced net costs, resulting in lower out-of-pocket expenses. However, the consumer is not required by the plan provisions to access preferred providers to receive benefits (including indemnity and the out-of-network benefits provided under PPO and POS products). The plan creates no benefit or cost sharing level incentive for the member at or prior to the point of service to use a certain provider. Members may select the provider of their choice and we access the discount. Unfortunately, if the provisions of this rule stand without modification we believe OCI will make us comply with the provisions of Subchapter III. Since these discounted fee arrangements are not designed for benefit steerage and often are difficult to obtain from health care providers, this program could not comply with the network adequacy, provider directory and continuity provisions of the regulation. We would be forced to cease using these arrangements and members would pay more as a result of the discounted savings being lost.

INS 9.34 (2) (c) Access Standards

Current Language: Provide 24-hour nationwide toll-free telephone access for its enrollees.

Recommended Clarification: Insert language to clarify that a 24-hour nurse hotline meets this access requirement.

INS 9.35 (1) Continuity of Care

Current Language: Upon termination of a provider from a managed care plan, the plan shall appropriately notify all enrollees of the termination, provide information on substitute providers, and at least identify the terminated providers within a separate section of the annual provider directory.

Recommended Change: Insert the term "affected" after "all" and before "enrollees." Phrase will read, "...the plan shall appropriately notify all affected enrollees of the termination..."

Rationale: Sending notice to *all* enrollees adds administrative costs to our plans without adding any additional consumer protections. We believe that health plans should be required to notify all *affected* enrollees of the termination. Affected enrollees include those who have received treatment or are currently receiving treatment from that provider. It would cost Humana with its 200,475 members an **additional $416,100 in administrative costs annually** to provide notices to all members. In most cases the notices would go to members that are not affected by the change. In some cases notice would be going to members residing on the other side of the state from the terminating provider since the rule does not limit the notice to a service area (Humana's HMO and PPO service areas include counties covering the state from Kenosha to Superior and Lake Michigan to the Mississippi River.)

Sub. (1) (a)

Current Language: If the terminating provider is a primary provider and the managed care plan requires enrollees to designate a primary care provider, the plan must notify each enrollee who designated the terminating provider of the termination the greater of 30 days prior to the termination of 15 days following the insurer's receipt of the provider's termination notice.

Recommended Change: Eliminate the 15-day provision and require health plans to provide notice 30 days prior to the termination.

Rationale: We recognize the need to notify enrollees of the termination of their primary provider. However, the "greater of" language in the rule creates an interesting problem. A provider may notify a plan of his intentions to terminate as much as 180 days from the effective date of that termination. Oftentimes health plans negotiate with these health care providers after a termination notice has been submitted and ultimately the provider does not terminate his/her contract. Under the rule, health plans would have to notify an enrollee within 15 days of receipt of a provider's notice to terminate yet the provider might not actually terminate. This situation can cause undo panic and anxiety for our members. Members may change providers because of the notice only to find later that the provider continues to participate. Plans would also have to incur that added expense of sending a second notice informing members that the provider is continuing in the plan's network. Limiting the notice to 30 days allows the health plan to require substantial advance notice in order to continue to negotiate with health care providers and avoid a service disruption. Thirty days still provides adequate notice to enrollees.

INS 9.37 (2) Notice Requirements

Current Language: Managed care plans shall mail or deliver current provider directories to enrollees upon enrollment, and no less than annually, following the first year of enrollment.

Recommended Change: Managed care plans shall make current provider directories available to enrollees upon open enrollment, and no less than annually, following the first year of enrollment.

Rationale: Our current practice is to provide information regarding the network in two basic ways: printed directories and a toll free provider verification number. We currently distribute these directories at open enrollment through the participating employer and at other times upon request. It takes about two printed directories per subscribers under this system. Based on our experience with the state employee health plan, which does require directories are mailed to each subscriber annually, we would have to print 40 percent more directories. Humana estimates that **this requirement including postage and printing will add $258,000 in costs annually**. At the same time, a member can turn their identification card over and find a toll-free number that will provide them with up-to-date information and verification of the health care providers that are available within our plans network. We believe the requirement to mail or deliver adds unnecessary administrative expense and should be eliminated.

Thank you for your consideration of these changes. If you have questions, please feel free to contact Humana representatives: Allan Patek (920-337-5618), Andrea Dilweg (920-337-5553), or Ann Jabloski (608-251-0702).

Humana is one of largest health insurer providers in the state providing HMO, PPO, POS and managed indemnity coverage as well as self-fund plan administration to more than 500,000 state residents. Humana's health plans include Humana/WHO, Emphyses Wisconsin, and Employers Health Insurance

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State Representative
Bonnie L. Ladwig
63rd Assembly District

Assistant Majority Leader

September 14, 1999

SEP 13 1999

State Representative Gregg Underheim, Chair
Assembly Committee on Health
11 North, State Capitol
Madison, Wisconsin 53708

Dear Chairman Underheim and members of the Assembly Health Committee:

I would like to express my support for Clearinghouse Rule 98-183 relating to revising requirements for managed care plans and limited service health organization plans. As you know, a lot of effort has gone into making this consumer friendly. I am pleased the legislative process has worked to address concerns of individuals.

I particularly want to note the 72 hour provision for appeal procedures that is included in the rule. This could be very beneficial to a patient who immediately needs a certain medical procedure or prescription not covered by the managed care plan.

I am also very pleased with the updated approach to the grievance procedures. It seems that this will allow for an independent review and also keep the consumer more informed about the process and who is making the decisions. Although the specific aspects of the procedure do seem a little cumbersome to the average patient.

Overall, I am excited that these changes are taking place at the state level. Patients have a right to be protected and informed when it comes to one of their most precious commodities – their health.

I would greatly urge your approval of these rules and allow for the formal implementation of these patient protection measures.

Sincerely,

Bonnie

Bonnie Ladwig
State Representative
63rd Assembly District

BLL:jlh

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Cc: Members of the Assembly Health Committee:

State Representative Frank Urban, Vice-Chair
State Representative Joe Handrick
State Representative Scott Walker
State Representative Frank Lasee
State Representative DuWayne Johnsrud
State Representative Luther Olsen
State Representative Steve Wieckert
State Representative Jean Hundertmark
State Representative Sheldon Wasserman
State Representative Tim Carpenter
State Representative Peggy Krusick
State Representative John LaFave
State Representative Mark Meyer
State Representative Mark Miller
State Representative Dan Schoof

TESTIMONY BEFORE THE ASSEMBLY HEALTH COMMITTEE

September 14, 1999

Members of the Committee:

My name is Christopher Queram. I am CEO of The Alliance, an employer-owned and directed health care coalition. I am here on behalf of The Alliance and our more than 1,000 member employers and associations to support the Managed Care Rule in general, and to urge important technical changes to clarify the role of organizations such as ours.

The Draft Rule provides important protections to consumers who have coverage through managed care plans. The Alliance is fully supportive of the Rule with regard to financial and market conduct standards for HMOs and other applicable plans. Strengthening the grievance procedure, for example, is an important consumer protection. Likewise, access to care and continuity of care in managed care plans where access may be limited, are important from a public policy perspective.

We note that the OCI has correctly recognized that certain indemnity insurers contract with providers for fee discounts and then pass these discounts along to their enrollees in the form of co-insurance differentials. These "managed cost" arrangements allow indemnity carriers to provide some increase in benefits to their enrollees when the enrollees use providers who have agreed to a fee discount. While most of The Alliance members are self-funded and not subject to the OCI's Rule, some of our participants, especially smaller employers and associations, are fully insured. Insurance companies providing coverage to these members, at The Alliance members' request, provide a reduction in the employee's co-insurance payment when the enrollee uses a provider contractually bound to provide discounted rates. This is a win-win situation, as it provides the consumer with total freedom of choice *and* an opportunity to use lower cost providers. The OCI has recognized that plans that only provide this single incentive cannot comply with the requirements applicable to an HMO managing the care, and are merely passing along cost savings. The Draft Rule at INS. 9.32 provides an exemption. We agree with the exemption in principle. However, there are some technical drafting problems with the Rule that need to be clarified. As drafted, the Rule is circular, and confusing. It could be interpreted in such a way that our members (largely small employer) and associations who have insured plans would have to stop offering this benefit to their employees. Indemnity plans cannot create compliance plans, institute quality assurance/data collection functions or determine the adequacy of the network for particular enrollees or for particular medical specialties. These are appropriate functions of managed care systems where access to care is limited and gatekeepers are in place. We propose that the exemption provision of the Draft Rule be clarified so that plans that offer comprehensive benefits to their insureds of at least 80% coverage for in-plan providers, make no representations regarding quality of care, and *only* provide a financial incentive to insureds as a co-insurance differential are exempted from those portions of the Rule that cannot logically apply to it. Of course the provisions of the rule governing grievance procedures, gag clause policy and certificate language requirements and disenrollment protections for consumers should fully apply to all plans, including "managed costs" plans.

These "managed costs" indemnity-type plans, offer complete freedom of choice of providers and are important to those employers, associations, and consumers who do not want to be part of an HMO but who want the cost benefits of seeking care from providers who are willing to discount their rates. It would be a great loss if this product were no longer available in Wisconsin because of a technical problem with the regulation. We could potentially be limiting the range of health care coverage choices available to employers and their employees and increasing the number of Wisconsin citizens who lack access to insurance coverage.

The Alliance will no longer be able to offer its network to its members who have insurance unless the technical problems with the Draft Rule are fixed. We stand ready to work with the OCI to fix them.

State Medical Society of Wisconsin
Advancing the health of the people of Wisconsin

TO: **State Representative Gregg Underheim, Chair**
Members, Assembly Committee on Health

FROM: **M. Colleen Wilson, Legislative Counsel**
Government Relations

RE: **Managed Care Rules (CR 98-183)**

DATE: **September 14, 1999**

The State Medical Society of Wisconsin appreciates the opportunity to address the proposed managed care rules. Physicians are generally pleased with the rules as submitted to the Legislature, and are grateful that suggestions that the Medical Society made to the Office of the Commissioner of Insurance (OCI) have been incorporated into the current version of the proposed rules. Language added to the sections on gag clauses clarifies these important provisions so that plans may not limit a provider's ability to disclose information about treatment options, and keeps the rules consistent with statutory language. The Medical Society also is pleased with the language regarding expedited grievances and believes the language as drafted provides more protections for patients in need of a more immediate decision.

The Medical Society does have a few suggestions for improvement in the proposed rules. Of primary concern to physicians is the language in the rules that would allow an employee of a health plan to serve as the enrollee member of a grievance panel. This provision is unacceptable as it jeopardizes the integrity of the process and puts a tremendous burden on the employee who may be in a position of serving multiple interests. Physicians believe having an enrollee on the grievance panel makes sense, however, allowing the enrollee to be an employee of the plan renders it meaningless.

We remain concerned that the language regarding continuity of care does not specify that the treating physician is to determine the course of treatment. The course of treatment for a particular condition varies from patient to patient and the treating physician, not a payer, is in the best position to determine, based on medical necessity and appropriateness, what the course of treatment needs to be to ensure the patient's well-being.

The SMS also favors more upfront disclosure by plans of what their policies include, especially with regard to requirements for prior authorization and utilization review. Physicians' intent in pursuing patient's rights legislation is to make sure that patients have all the information they need about their insurance to prevent surprises when the coverage is actually needed. In secs. 9.37 and 9.38, managed care plans and limited service health organization plans are required to provide some limited information to enrollees. The Medical Society believes this list should also include deductible and coinsurance requirements, the person(s) who makes utilization review decisions and how those decisions are made, loss ratios, pharmaceuticals approved for use and a detailed description of the grievance process.

The State Medical Society appreciates the opportunity to express its support for the proposed rules, with the changes proposed herein. We look forward to working with committee members to ensure that patients enjoy the benefits of the Managed Care Consumer Protection Act.