Association of
Wisconsin **HMOs**

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September 14, 1999

To: Members, Assembly Health Committee

From: Nancy J. Wenzel, Executive Director
Julie A. Daggett, Director of Government Affairs

RE: Clearinghouse Rule (CR) 98-183, Managed Care Regulation

Attached, for your information, is a chart containing the aggregate comments of Wisconsin HMOs on the third draft of CR 98-183, managed care regulation—the version of the rule before the Committee today. The Association of Wisconsin HMOs is recommending several primarily technical modifications to ensure that the rule's requirements are implemented uniformly by insurers and are easily understood by consumers.

Members of the HMO Association have worked diligently over the past several months to help craft a rule that: is consistent with statutory language; meets patients' needs; and does not divert limited health plan resources away from patient care and toward unnecessary administrative tasks.

Wisconsin HMOs consider the issues in the attached chart the key outstanding obstacles to achieving this goal.

We look forward to working with members of the Assembly Health Committee to ensure that the managed care rule appropriately enforces the provisions of the 1998 Managed Care Law.

ASSOCIATION OF WISCONSIN HMOs

Association Recommendations on Draft 3 of CR 98-183, Managed Care Regulation

9/14

Page/Section	Section Topic	Draft 3 Rule Language/Provision(s) (Changes from Draft 2)	Association Recommendation/Rationale
	Medicare+Choice		
Pg. 3 INS 3.39 (7) (g)	Compliance with the Rule	Insurers writing Medicare+Choice plans shall additionally comply with ch. Ins 9, subchapters I and III.	**Recommendation**: Delete all references to Medicare+Choi compliance with the rule.
Pg. 6 INS 9.01 (12)	Managed Care Plan Definition	Managed care plan has the meaning provided under s. 609.01 (3c), Stats., and includes Medicare+Choice plan as defined in s. 3.39 (3) (cm), Medicare Select policy as defined in s. 3.39 (30) (b) 4., and health benefit plans that either directly or indirectly contract for use of providers.	**Rationale**: Medicare+Choice is a federal program regulated the Health Care Financing Administration (HCFA). HMOs a concerned about conflicts and consumer and insurer confusi related to dual regulation by federal and state agencies that may interpret the same rule differently. **HMOs continue to request that the Office of the Commissioner of Insurance (OCI) seek specific written clarification from HCFA that authorizes OCI to regulate Medicare+Choice plans and that details which regulator prevails when conflicts arise.**
Pg. 16 INS 9.33 (1) (b)	Grievance Procedure	b) Insurers issuing Medicare+Choice plans shall follow the Medicare+Choice grievance and appeal procedures in accordance with 42 CFR s. 422.561 (1998), unless the insurer determines that a grievance or appeal is not subject to 42 CFR s. 422.561 (1998) and then the insurer shall follow the procedures set forth in this section.	
Pg. 20 INS 9.35 (4)	Continuity of Care	(4) Medicare+Choice plans are not subject to s. 609.24 (1) (e), Stats., in accordance with 42 USC 1395w-26 (3) (B) ii.	

Page/Section	Section Topic	Draft 3 Rule Language/Provision(s) (Changes from Draft 2)	Association Recommendation/Rationale
Pg. 16 INS 9.33 (1) (a)	Grievance Procedure	Each managed care plan and limited service health organization plan shall incorporate within its policies, certificates or outline of coverage, if required, the definition of a grievance in s. INS 9.01 (5). The managed care plan or limited service health organization plan shall develop an internal grievance procedure that shall be described in each policy and certificate issued to enrollees at the time of enrollment or issuance. The insurer shall provide a notice within each policy and certificate issued to enrollees describing that if a provider denies of a request for a referral from an enrollee, the enrollee has a right to additionally request the referral from the insurer. In accord with s. 609.15 (1) (a), Stats., managed care plans and limited service health organization plans shall investigate each grievance.	**Recommendation:** Delete new language in draft 3. **Rationale:** New language in draft 3 advocates for insurers t make medical decisions by overriding the medical judgemen of providers. Deletion clarifies that providers, not insurers, a responsible for making referral decisions.
Pg. 17 INS 9.33 (5) (d)	Grievance Procedure	"In addition to the requirements of s. 609.15 (2) (b), Stats., the grievance panel shall not include the person or persons who ultimately made the initial denial determination~~, or the person's or persons' subordinates.~~ The panel may include no more than one of the person or persons' subordinates only if the panel consists of at least three persons. The panel may, however, consult with that person or persons."	**Recommendation:** Revise second sentence as follows: "The panel may include ~~no more than~~ one of the person or persons' subordinates ~~only~~ if the panel consists of at least three persons." **Rationale:** Clearer language.
Pg. 19 INS 9.34 (2) (c)	Access Standards	"(c) Provide 24-hour nationwide toll-free telephone access for its enrollees."	**Recommendation:** Modify as follows: "(c) Provide ~~24-hou~~ nationwide toll-free telephone access for use by its enrollees (d) Provide 24-hour telephone access to the plan or to a participating provider for authorization for care which is covered by the plan." **Rationale:** The proposed rule language goes beyond the legislative intent of 609.22 (7) because it combines two distinct legislative objectives into one provision. The statutory language requires telephone access for sufficient time during business and evening hours but only requires 24-hour telephone access to the plan or to a participating provider. Because of the passage of 632.85, relating to emergency services, no patient is required to get prior authorization for treatment of an emergency medical condition.

Page/Section	Section Topic	Draft 3 Rule Language/Provision(s) (Changes from Draft 2)	Association Recommendation/Rationale
Pgs. 19-20 INS 9.35 (1) (a)-(c)	Continuity of Care	**Draft 3 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. In addition, the plan shall comply with the following as appropriate: (a) If the terminating provider is a primary care provider and the managed care plan requires enrollees to designate a primary provider, the plan shall notify each enrollee who designated the terminating provider of the termination the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice and shall describe each enrollee's options for receiving continued care from the provider. (b) If the terminating provider is a specialist and the managed care plan requires a referral, the plan shall notify each enrollee authorized by referral to receive care from the specialist of the termination the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice and describe each enrollee's options for receiving continued care from the terminated provider. (c) If the terminating provider is a specialist and the managed care plan does not require a referral, the provider's contract with the plan shall comply with the requirements of s. 609.24, Stats., and require the provider to post a notification of termination with the plan in the provider's office the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice.	**Recommendation:** Replace language in draft 3 with draft 2 language as follows: "(1) Upon termination of a provider fr a managed care plan, the plan shall notify all affected enroll of the termination and each enrollee's options for receiving continued care from the terminated provider not later than 3 days prior to the termination. A managed care plan shall provide information on substitute providers to all affected enrollees. Affected enrollees include the following: (a) If th individual provider is a primary care provider and the plan requires enrollees to designate a specific primary care provider, the plan shall notify all enrollees who designated th terminating individual provider." **Rationale:** • Draft 2 language with suggested modifications clarifies tha affected enrollees are only those who are required to select a specific, individual provider as their primary care provider. • Language in draft 3 goes beyond the continuity of care statutory requirement to provide coverage of services from a provider if the plan represented in marketing materials that th provider would be a participating provider. • Language in draft 3 creates a bureaucratic morass that will ultimately be confusing to patients. • The requirement to create a special section in the annual provider directory will not result in timely notification but will result in additional administrative expenditures. An insurer with 200,475 enrollees estimates the cost to mail the special section of termed providers at $416,000 per year.
Pg. 20 INS 9.35 (2) (a) & (b)	Continuity of Care	(2) A managed care plan is not required to provide continued coverage for services of a provider if either of the following are met: (a) The provider no longer practices in the managed care plan's geographic service area. (b) The insurer issuing the managed care plan terminates the provider's contract due to **professional misconduct** on the part of the provider.	**Recommendation:** Modify (b) to read: "The insurer issuing the managed care plan terminates the provider's contract due to ~~professional~~ misconduct on the part of the provider including failure to meet the criteria under 609.32 (2) (b), quality assurance." **Rationale:** Makes language consistent with requirements/definition in s. 609.24, (1) (d) (2) Stats. Also allows for exemption to continuity of care if the provider does not meet the requirements under 609.32 (2) (b).

Page/Section	Section Topic	Draft 3 Rule Language/Provision(s) (Changes from Draft 2)	Association Recommendation/Rationale
Pg. 20 INS 9.37 (2)	Provider Directories	Managed care plans shall mail or deliver ~~make~~ current provider directories ~~available~~ to enrollees upon enrollment, and no less than annually, following the first year of enrollment.	**Recommendation:** Maintain draft 2 language requiring plan to make directories available. **Rationale:** Requirements in draft 3 are extremely cost prohibitive and do not provide added benefit to patients. A plan with less than 25,000 enrollees estimates the cost at $138,000 to print and mail provider directories to all enrollees on an annual basis. A plan with 140,000 enrollees estimates the cost at $258,000 per year. These resources are better directed toward direct patient care. Plans currently make updated directories available to interested enrollees on a regular basis without complaint.
Pg. 23 INS 9.40 (3) & (4)	Quality Assurance Plans	(3) Beginning June 1, 2002, every health maintenance organization ~~managed care plan, limited service health organization plan 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 June 1 of each year. ~~No later than August 1 of each year, the commissioner shall prepare a summary report on the collected data.~~ (4) Beginning June 1, 2003, every managed care plan, limited service health organization plan 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 June 1 of each year.	**Recommendation:** Modify HEDIS deadline as follows: "Beginning June 15 ~~1~~, 2002, every health maintenance organization shall submit its HEDIS data each year . . . no later than June 15 ~~1~~, or the HEDIS submission deadline established by the National Committee for Quality Assurance." **Rationale:** The current NCQA HEDIS submission deadline is June 15. The language allows for future NCQA deadline changes.

TO: Members
Assembly Committee on Health

FROM: Carol Trocinski
Midwest Security Life Insurance Company

DATE: September 14, 1999

SUBJECT: OCI Managed Care Rule

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.

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.

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.

touchpoint™
HEALTH PLAN

(HMO)
1/30/97–1/30/00

Written Comments to the Assembly Health Committee
Re: Revision of Patients' Rights/Managed Care Rules
Tuesday, September 14, 1999 10:00 A.M.
State Capitol Room 417-N

Dear Chairman Underheim and Members of the Committee:

I am writing today to provide constructive comments regarding the latest draft of rules submitted by the Office of the Commissioner of Insurance implementing the patients' rights legislation.

Touchpoint Health Plan™, then known as United Health of Wisconsin, was the only managed care plan to publicly support and testify in favor of this legislation when it was considered last year.

Touchpoint Health Plan is based in the Fox Valley and is currently the 4th largest managed care plan in Wisconsin with more than 136,000 HMO members and nearly 150,000 people covered by our preferred provider plans. Touchpoint is owned in partnership by ThedaCare™ (formerly United Health Group) and Fox Valley independent physicians. Aurora Health Care and Bellin Health also own 25% and 15% of Touchpoint respectively. We have Commendable Accreditation from the National Committee for Quality Assurance.

Our concern with the latest draft of the rules is that some provisions will have unintended and unnecessary consequence of increasing premiums with no tangible benefit to our members. In some cases, the changes will actually reduce the quality of medical care being received by our members. Specifically:

1. **The latest draft of Ins. 9.33 requires 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.***

First, there is no authority for this provision in the original legislation which was signed by the Governor, and for good reason. The managed care organization does not practice medicine. If a physician in the plan believes a referral is not necessary, every member already has the ability to seek a second opinion from another physician. If it is the opinion of a second physician that a referral is not needed, it seems ludicrous to put the insurance company in the position of overriding the sound medical judgement of two licensed physicians. We urge the committee to reject this rule.

2. Draft of Ins. 3.39(2)(g) regarding Medicare + Choice required compliance with Ins. Chapter 9 and subchapters I & II. Additionally, Ins. 9.01(12) includes Medicare + Choice plans in the definition of Managed Care Plans.

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We believe this is inappropriate. Medicare + Choice plans are already regulated by the United States Government through HCFA. There is no stated affirmation from HCFA to OCI giving the state authority to regulate these plans, or even indicating whether state of federal rules take precedence. Multiple, conflicting regulation only leads to additional administrative costs which must be born by our customers with no demonstrable benefit to them. We urge the Committee to reject this provision.

3. **Draft of Inc. 9.35(1). This provision currently reads *Upon termination of a provider from a managed care plan, the plan shall appropriately notify all affected 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...***

Unfortunately, the OCI has removed the word "affected" in the latest draft. Depending upon interpretation, this means managed care organizations would have to produce a mailing to each member each time a physician leaves the panel. In our case, each mailing to all enrollees costs more than $15,000. With nearly 1000 empanelled physicians, this has the potential to increase our administrative costs by $500,000 to $1,000,000 annually - half of that attributed to physicians retirements. We recommend that the OCI re-insert the word "affected" into the text. This will assure that all plans notify members when their personal physician leaves the plan without the cost of a blanket mailing to all members.

4. **In the draft of Ins. 9.37, OCI requires that managed care plans *mail or deliver* provider directories no less than annually following the first year of enrollment.**

The current law only requires that provider directories be supplied at enrollment, with updates *available* annually. Requiring that updated directories be mailed each year regardless of the members' need for an updated directory will add a minimum of $100,000 to our annual cost. This is unnecessary since these directories are already available at enrollment, on-line and upon request. We urge the committee to reject this version of the rule.

We hope these comments and explanations of our concerns are helpful to the committee as you consider this latest draft. We remain fully committed to Patients' Rights, and only hope the committee to strike those revisions which are bad public policy, such as the required referral provision, or which add unnecessary costs to the managed care plans without any benefit to the quality of care received by our members.

Sincerely,

Dean Gruner, MD
Chief Medical Officer
Touchpoint Health Plan™

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Testimony to
Assembly Health Committee
September 14, 1999

by Connie L. O'Connell
Commissioner of Insurance

Thank you, Representative Underheim, and members of the Committee for the opportunity to present testimony regarding Ins 9, the proposed managed care rule to be promulgated by the Office of the Commissioner of Insurance. I am Connie O'Connell, Insurance Commissioner. With me today is Eileen Mallow, an analyst with our agency.

We are pleased to have the opportunity to share with you the rules we propose to promulgate for the regulation of managed care plans in Wisconsin. It is with pride that I can tell you that Wisconsin continues to lead the nation in the regulation of managed care plans specifically and health plans in general.

Ins 9 implements statutory changes from **1997 Wisconsin Act 237** and **1997 Wisconsin Act 155**. Act 155 went into effect on November 1, 1998 and the Act 237 managed care provisions went into effect on January 1, 1999. The statutes are proscriptive about what is now expected of health plans. As a result, the rules are generally more geared towards how OCI, the legislature, and the public can be assured that health plans are meeting the statutory requirements.

The rule before you, I believe, is a reflection of the intent of the legislature in its passage of Acts 155 and 237. Clearly, with the passage of Acts 155 and 237, the legislature set into motion a new landscape in the regulation of health plans in our State. During the rule development process, OCI provided ample opportunity for public review and comment. The first draft of the rule was released in November 18,

1998, with a public hearing on December 6, 1998. Based on comments received at the rule hearing, a second draft of the rule was released in March 1999, with a second public hearing held on April 9, 1999. The final rule draft considers the comments from both hearings, as well as individual meetings the agency has held with insurer and consumer representatives.

Statutory Changes – Two bills from the 1997 session provided the statutory basis for the administrative rule. Briefly, the statutory changes may be summarized as:

Act 155 requires health insurers, both managed care and traditional indemnity insurers, to provide coverage for treatment provided in any emergency room as long as the symptoms were such that a **prudent layperson** would reasonably consider the situation to be an emergency. This benefit is limited to those policies that cover emergency services. Payment under the policy may be limited to that needed to stabilize the patient.

Act 237 implemented significant changes in **managed care regulation**, starting with the definition of managed care.

Managed care is now defined as any health insurance policy that creates incentives, including financial incentives, for enrollees to use providers that are directly or indirectly under contract to the insurer. This is an intentionally broad definition of managed care. In working on the proposed legislation, the Legislature wisely avoided the alphabet soup that now characterizes the health care system. In many cases, consumers are not aware of the distinctions among the different entities; they are all HMOs to consumers. As an example, the Legislature could have indicated the requirements apply to HMO's but not PPO's. This could create an unfortunate environment where entities currently operating as HMO's simply make a few changes, call themselves PPO's and become exempt from the statute. Instead, the Legislature crafted a reasonable set of expectations for plans that manage the care delivered, regardless of what they call themselves. While the definition then ended up capturing a wide variety of health insurance products, we continue to believe that

an appropriate regulatory approach for all the products has been created with this rule.

Two of the Act 237 changes apply to all health plans, appeal of **coverage of experimental procedures and an appeal process for non-formulary drugs**. Under Act 237, all health plans must clearly identify any coverage limitations on experimental procedures and offer an appeal mechanism for enrollees who have coverage of experimental procedures denied. In addition, all health plans, that have lists of pre-approved drugs, often referred to as formularies, must also now have a process where the enrollee's physician may submit medical evidence supporting the use of a non-formulary drug.

Other changes that were enacted with Act 237 include the following:

- Provisions, known as **continuity of care**, that permit enrollees to see their physician for a set amount of time after the physician is no longer under contract with the health plan. Wisconsin now has the strongest continuity of care provisions in the country. Specifically, the statute requires managed care plans that represent to potential enrollees that providers will be available to live up to that representation. If provider/plan contract ends during the middle of a policy year, and it is the enrollee's primary provider, the enrollee has the right to see the provider through the contract year. If it is a specialist provider, the enrollee has the right to see the provider for the lesser of 90 days or through the current course of treatment. If it is an OB/GYN and the woman is in her second trimester of pregnancy or later, the enrollee has the right to see the provider through post-partum care. The only exceptions to this statute are if the provider leaves the managed care plan service area or is terminated from the managed care plan for misconduct. Please note that while the statute establishes terms for any continuing relationship between the provider and the health plan for this circumstance, there is no requirement that a provider continue to see the enrollee.
- Wisconsin has had statutory language for many years that forbids the interference by insurers in the provider/patient

relationship. However, the provisions that barred **gag clauses** in provider contracts were strengthened in Act 237.

- Managed care plans are required to meet **access standards** that include having an adequate number and type of providers to meet the health needs of their enrollees.
- Managed care plans are required to have **quality assurance plans** and report their quality data to the Insurance Commissioner.
- Managed care plans are required to have a process to permit an enrollee to have a **standing referral to a specialist provider**, where medically justified.
- Managed care plans are required to pay for a **second opinion** from an in-plan provider.

Federal changes, notably the Balanced Budget Act of 1997 (BBA), have also come into play during development of this rule. The BBA created **Medicare + Choice** plans as another means of delivering Medicare benefits to senior citizens, that are generally provided by managed care plans. Medicare + Choice plans are one year contracts signed between the federal Health Care Financing Administration (HCFA) and the individual health plans. BBA allows states to regulate Medicare +Choice plans to the extent that the state regulation is consistent with and does not interfere with federal statutes and regulations. Much of Wisconsin insurance law applies to Medicare+Choice plans and is not preempted under this standard. The managed care rule spells out the areas where Wisconsin law continues to apply. We are able to collect information on the numbers of complaints and grievances filed against plans and regulate some of the marketing activities of Medicare + Choice plans.

Major Concern Expressed Regarding the Rule and How It Was Addressed

- **Definition of Managed Care**

At the agency rule hearing in December, health plans identified a number of problems with the rule, most notably with the scope statement. Many of the less managed versions of managed care, such as Preferred Provider Organizations (PPOs), expressed concerns with the impact the rule would have on the health insurance market. The

managed care statutes cast a broad net. However, OCI, to the extent it can within the statutory framework, has crafted the rule to recognize the differences between the various types of managed care insurance coverage in the market and to avoid imposing requirements on these plans that would be difficult or impossible to meet. In order to address these concerns, OCI simplified the requirements for plans that can document they meet certain standards.

These plans, who often refer to themselves as discount networks, fill an important market niche by offering coverage to farm families or others who need individual health insurance coverage. The plans contract with provider networks and are able to offer discounted prices when the enrollee uses the network, but permit the enrollee to also go off-panel, at a higher price. Plans that offer greater flexibility to their enrollees can reasonably argue that they should not be subject to the same level of regulation as the more restrictive health plans.

In easing up some of the reporting requirements, we did not want to create incentives for plans to establish networks with very low coverages on non-network services, or to have inadequate numbers or geographical distribution of providers. OCI considers accurate description of the health plan and its benefits at the time a plan is marketed to be an important consumer protection. Enrollees should not be surprised at the coverage percentages when they receive their provider's billing statement. While OCI has eased up the reporting requirements for the least "managed" versions of managed care, we believe the criteria for plans to receive this flexibility is narrow enough that we do not create a loophole in the law.

To qualify for the lesser documentation requirements, a plan must meet all of the following:

- offer at least 80% coverage,
- no more than a 10% differential to the enrollee between using a plan provider and a non-plan provider,
- no mechanism other than cost for steering patients to providers,
- does not make enrollees bear additional cost when a network does not have adequate providers, and
- does not make any claims about the quality of care provided by their health plan.

Plans meeting these conditions will still have to follow the continuity of care and grievance procedures in statute, certify to the Commissioner that they have an adequate provider network, and ensure that any subcontracts meet the requirements of the law.

Outstanding Concerns

Although we were able to resolve many of the concerns with the rule, we are aware of a number of outstanding issues.

- **Definition of Managed Care**

  The broad scope of the legislation continues to generate concern. Some plans believe the narrowly crafted language relaxing requirements on the least managed plans does not go far enough. They believe the language should be written more broadly to apply to more plans and that additional requirements should be lifted from these plans. We believe it is neither possible nor desirable to modify this language further. The broad definition of managed care is based on the original legislation, not an OCI interpretation. Therefore, to create a larger loophole would require legislative change. Further, the original intent of the legislation was to create a level playing field for managed care plans. A broader definition would create an incentive for plans to modify their structure in order to avoid some of the consumer protections created by the original legislation.

- **Medicare Plans**

  Medicare + Choice and Medicare Select, two versions of Medicare managed care, are included in the rule to the extent permitted under federal law. After careful review of the BBA and federal regulations, the areas over which we have limited regulatory authority include marketing and appeals that are not subject to the Medicare appeal process. Medicare managed care plans will also be required to report all appeals (grievances) to OCI. Some HMO's have raised concern regarding the inclusion of these plans under the statute. While we are aware of this concern, we believe the state has an obligation to provide individuals enrolled in these plans with as much protection as allowed under state and federal law.

- **HMO Financial Concerns**

  In early September, my office announced that reports filed by HMOs showed they had lost a combined $18.6 million during the 2nd quarter of 1999. Some may suggest this is not the time to impose requirements on managed care plans given their financial condition. However, the recent poor fiscal performance of the HMO industry has little to do with regulation. The losses reflect competitive pressures in the Wisconsin health insurance market and health care costs. All health insurers are faced this year with rapidly increasing costs for pharmaceuticals, a change in their ability to contract with health care providers, and providers inability to cost shift, making them less able or willing to negotiate prices. These rules reflect statutory changes which in turn reflect consumer demands for accountability of their health plan. We believe that this rule implements the statutory mandate to provide the accountability demanded by consumers balanced against the financial experience of managed care plans.

OCI continues to work on implementation of the rule. For example, the rule makes reference to several forms. OCI will be working with interested parties as it develops these forms.

Last year, the Wisconsin Legislature adopted a comprehensive framework of consumer protection in the area of managed care. While the major policy requirements have been in place since the beginning of this year, this rule provides the final step in making these protections a reality. Thank you for the opportunity to present this testimony. I would be happy to answer any questions you may have.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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October 1, 1999

The Honorable Gregg Underheim
State Representative
11 North Capitol
Madison WI 53701

RE: Ins 9, Wis. Adm. Code

Dear Representative Underheim:

After careful consideration of the comments offered at the Assembly Health Committee hearing on our proposed administrative rules on managed care plans, I would like to recommend the following technical changes to the rule:

Ins. 9.35 Continuity of Care. Amend the language to read:

(1)(a) Upon termination of a provider from a managed care plan, the plan shall ~~appropriately~~ notify all affected enrollees of the termination and each enrollee's options for receiving continued care from the terminated provider not later than 30 days prior to the termination, or upon notice by the provider. A managed care plan shall~~,~~ provide information on substitute providers to all affected enrollees. ~~, and at least identify the terminated providers within a separate section of the annual provider directory. In addition, the plan shall comply with the following as appropriate:~~

~~(a)~~ **(b)** If the ~~terminating~~ provider is a primary provider and the ~~managed care~~ plan requires enrollees to designate a primary provider, the plan shall notify ~~each~~ all enrollees who designated the terminating provider ~~of the termination the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice and shall describe each enrollee's options for receiving continued care from the terminated provider~~.

~~(b) If the terminating provider is a specialist and the managed care plan requires a referral, the plan shall notify each enrollee authorized by referral to receive care from the specialist of the termination the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice and describe each enrollee's options for receiving continued care from the terminated provider.~~

~~(c) If the terminating provider is a specialist and the managed care plan does not require a referral, the provider's contract with the plan shall comply with the requirements of s. 609.24, Stats., and require the provider to post a notification of termination with the plan in the provider's office the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice.~~

Rep. Gregg Underheim
October 1, 1999

Ins 9.35 (2) Continuity of Care

(b) The insurer issuing the managed care plan terminates the provider's contract due to ~~professional~~ misconduct on the part of the provider.

Ins 9.37 Notice Requirements

(2) PROVIDER DIRECTORIES. Managed care plans shall ~~mail or deliver~~ make current provider directories available to enrollees upon enrollment, and no less than annually, following the first year of enrollment.

Thank you for the time you have spent working towards resolving the remaining issues on the managed care rule.

If you have any questions about the proposed changes, please contact Eileen Mallow at 6-7843.

Sincerely,

Connie L. O'Connell

Connie L. O'Connell
Commissioner

cc: Randy Blumer
Guenther Ruch
Fred Nepple
Eileen Mallow

AMERICAN FAMILY INSURANCE
AUTO HOME BUSINESS HEALTH LIFE ®

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CR 98-183

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 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 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.

Lee Fanshaw

From: Fanshaw, Lee C <lfanshaw@amfam.com>
To: Fanshaw, Lee C <lfanshaw@amfam.com>
Subject: Re: Exemption Language Document
Date: Friday, October 08, 1999 12:38 PM

>
>
> Page 15 INS 9.32 Exemptions
>
>
> (1) Insurers writing managed care plans are exempt from meeting the
> requirements under ss. 609.22, 609.24, 609.32, 609.34, Stats.,
> ss. Ins 9.34, 9.35, 9.37(2), (3) and (4), 9.40 and 9.42, if the
> managed care plan meets all of the following requirements:
>
> (a) The plan's only financial incentive to the insureds is a
> co-insurance differential of not more than 10% between in-plan
> versus off-plan providers. Except for the co-insurance differential
> of no greater than 10%, all benefits, deductible and co-payments
> must be the same regardless of whether the insureds obtain
> benefits, services or supplies from in-plan or off-plan providers.
>
> (b) The plan makes no representations regarding quality of care.
>
> Health plans meeting this exemption must provide a written disclosure
> at the time of sale indicating that network providers may not be
> available in all geographic regions of the state.
>
>
>
>
>

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LS 9/9/99

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E-mail address: nparrett@lafollettesinykin.com

September 19, 1999

HAND DELIVERED

Fred Nepple
General Counsel
Office of the Commissioner of Insurance
121 East Wilson Street
P.O. Box 7873
Madison, WI 53707-7873

Re: Managed Care Rule
Proposed sec. Ins 9.42

Dear Fred:

We represent Delta Dental Insurance Plan of Wisconsin (Delta Dental). Delta Dental is a monoline insurance carrier, providing only limited-scope dental benefits. We have reviewed each iteration of proposed ch. Ins 9, Wis. Adm. Code, for its application to Delta Dental, and the Company or its representatives have had contact with the OCI on several occasions during the development of ch. Ins 9.

Delta Dental's understanding has always been that because of the nature of its insurance product, recognized by its exemption from HIPPA, it would be exempted from the rule. In fact, the Company is exempted from all of the provisions in Subchapter III on Market Conduct Standards for Managed Care Plans through the definition of "health benefit plan." The exception to this blanket exemption is proposed sec. Ins 9.42 on compliance program requirements. Subsection (1) of proposed sec. Ins 9.42 currently reads:

> All insurers writing managed care plans, preferred provider plans and limited service health organization insurers are responsible for compliance with ss. 609.15, 609.22, 609.24, 609.30, 609.32, 609.34 and 609.36, Stats., this subchapter and other applicable sections including but not limited to s.

> Ins 9.07. The insurers shall establish a compliance program and procedures to verify compliance with ss. 609.15, 609.22,609.24, 609.30, 609.32, 609.34, and 609.36, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07. Nothing in this section shall affect the availability of the privilege established under s. 146.38, Stats.

Delta Dental has a preferred provider network and is a preferred provider plan under sec. 609.01(4), Stats. It appears therefore that the Company would be subject to sec. Ins 9.42, Wis. Adm. Code. Section Ins 9.42 as currently drafted appears to bring Delta Dental back into all of the managed care rule's requirements from which the Company is exempted in the first instance by virtue of the definition of "managed care plans." We do not believe that this can be the intent and suggest the following modification in proposed sec. Ins 9.01(15) to clarify that Delta Dental is still exempted from subch. III of ch. Ins 9.

> (15) "Preferred provider plan" has the meaning provided under s. 609.01(4), Stats., <u>but does not include those coverages listed in s. 609.01(1g)(b).</u>

The only subdiv. in s. 609.01(1g)(b) that is applicable to Delta Dental is subdiv. 9. However, in reviewing each of the coverages listed in sec. 609.01(1g)(b), it becomes clear that it cannot have been the intent to include any of these coverages in the application of the managed care rule even though there may be some managed care component in providing the coverages, since they are also excluded from the definition of "managed care plan."

We appreciate your consideration of this request. Should you have any questions, please do not hesitate to call.

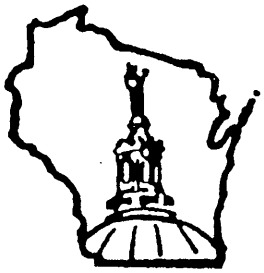
Sincerely

LA FOLLETTE SINYKIN, LLP

DRAFT
Noreen J. Parrett

cc: Susan Ezalarab
Julie Walsh
Eileen Mallow
Dennis Brown
Ron Hermes

Wisconsin Retail Associations Working Together



CONFERENCE of RETAIL ASSOCIATIONS

CORA

Midwest Equipment Dealers Association

Midwest Hardware Association

National Federation of Independent Business

Petroleum Marketers Association of Wisconsin

Wisconsin Association of Convenience Stores

Wisconsin Automobile & Truck Dealers Association

Wisconsin Automotive Parts Association

Wisconsin Automotive Trades Association

Wisconsin Grocers Association

Wisconsin Merchants Federation

Wisconsin Propane Gas Association

Wisconsin Retail Lumbermen's Association

Wisconsin Restaurant Association

To: Senator Rod Moen

From: Conference of Retail Associations (CORA)

Date: December 1, 1999

Re: Managed care rule

This memo addresses the managed care rule and its potential effect on health plans purchased by both large and small employers, like those represented in CORA. As you know, many of us have been concerned regarding the managed care rules and Chapter 609 of the Statutes.

Our concern with the rules and statutes is the failure to recognize the differences which exist between HMO's and PPO's. This could have wide sweeping affects on the businesses that purchase PPO type plans in Wisconsin. It should be noted that nationally, only about 30% of the insured population is enrolled in HMO's, while approximately 60% chose PPO type plans. These statistics are also representative of Wisconsin. The problem is, this legislation created managed care regulations based on the way HMO's provide care. Unfortunately it applies those same regulations to PPO's, which do business much differently than HMO's.

The question is not whether PPO plans should be regulated by Chapter 609, but that they be regulated appropriately. In our opinion, there are two primary concerns regarding Chapter 609 and the rules as described in Ins 9. At issue is whether health plans and their rented PPO networks have the ability to comply with two specific provisions. If they cannot comply with these provisions as written, those employers in the PPO type plans would be left with the option of going into an HMO plan, or to an indemnity plan. This will reduce choice to employers, and, raise costs. The two provisions are outlined below:

Chapter 609.22 and Ins 9.34 - <u>Access Standards</u>

The statutes and rules regarding access attempt to provide protections to enrollees relative to the number and type of providers

they can access for care, and when and how they can access these providers. The very nature of a PPO is to give its enrollees the ability to see any provider they want - inside or outside the network. PPO plans provide benefits and coverage for both, and therefore, there is no restriction on access. Many of our employers offer PPO's for this very reason - to give the freedom of choice to the enrollees.

The difficulty in attempting to comply with this provision is that the relationship between PPO's and the providers is not designed to "manage care", it is designed to obtain discounts from the providers. In contrast, the relationship between HMO's and providers is specifically designed to manage the care of the enrollee. One example in Ins 9.34 is the requirement for insurers to "file a certification with the commissioner" every year demonstrating the plan has the capability to provide health care with "reasonable promptness with respect to geographic location, hours of operation, waiting times for appointments in provider offices and after hours care". Currently, PPO plans don't have the contractual ability to control these factors, nor would the providers necessarily agree to these types of provisions within their relationship with the PPO. Therefore, our plans would simply not have the ability to comply with 609.22 and Ins 9.34.

Chapter 609.32 and Ins 9.40 - <u>Quality Assurance</u>
Similar to the concerns above, this provision places requirements on our health plans we will be unable to comply with. As an example, it requires that health plans assure the "health care services provided to the enrollees" meet the quality of care standards consistent with prevailing standards of medical practice in the community. There is no way for these types of health plans to meet that requirement, as they do not provide health care services. It further requires the plans to track medical outcomes, which again is not done by our plans.

While there has been some modifications proposed by the Center for Public Representation to this provision (November 4th Draft), and while we support the copy of draft language we received specific to that provision, it still does not address the access standards issue described above.

In the OCI's last version of Ins 9, they did propose language which would make some of the unreasonable provisions exempt for certain plans. While we were happy to see a movement by the OCI towards recognizing the differences between HMO's and PPO's, in their exemption (Ins 9.32), they narrowed the definition of what qualifies as a PPO plan. The exemption is for only those plans that offer no greater than a 10% co-insurance differential for in-network versus out-of-network, and also do not provide any other deductible or co-pay differentials. The exemption falls short of allowing plans to be able to continue to offer a variety of choices to the marketplace. If the restrictions on the exemption were more liberal to allow a variety of benefit plans, then this exemption would solve the issues addressed above.

We appreciate the difficulty the OCI has in trying to address our concerns, especially based upon the way the statutes were written. We also understand that their is a request to the department for an informal opinion as to how they would regulate these provisions based on how PPO type plans currently operate. If their opinion is supportive of our concerns, we would hope the legislature could revisit the statutes at a convenient time in the future. If, however, their opinion is not supportive, we would hope for a suspension of the rule until such time as the problem could be corrected.

GROUP HEALTH

COOPERATIVE OF EAU CLAIRE

November 11, 1999

Senator Rod Moen
8 South, State Capitol
Madison, WI 53702

Dear Sen. Moen:

Over the years, you have been a great supporter of Group Health Cooperative. On behalf of the 25,000 members served by Group Health, I want thank you for the level of attention you have given our issues in the Legislature.

Another one of those issues is again facing your committee – the rules drafted by the Commissioner of Insurance implementing the managed care laws enacted last year. As you know, I have worked on this law on both the regulatory side and now the industry side. While many people would expect this switch to create a change in my opinion, it hasn't. The main reason for the easy transition is the fact that we spent a considerable amount of time to draft a law that both consumer groups and insurers, including Group Health Cooperative, supported.

As the rule draft is nearing its final stages, one issue remains that creates a concern for Group Health. A number of insurers have contacted members of the Legislature and OCI seeking a broadening of the exemption from the statute and rule.

Ch. 609.01(3c), Wis. Stats. clearly states that an insurance policy is a managed care plan if it:

> "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."

Summarized, the statute considers an insurance policy a managed care plan if it offers any financial incentive to use network providers rather than out-of-network providers. Because of the subtle differences in the wide spectrum of insurance coverage available, this broad definition was included in the statute to prevent insurers from changing the name of the policy to escape regulation. This concept was supported by the parties at the table when it was drafted, including consumer groups and insurers.

Implementing statutes in the real world sometimes poses a challenge. OCI knew some level of leeway was necessary for plans that offer small discounts not intended to steer policyholders to network providers.

P.O. Box 3217 • Eau Claire, WI 54702-3217 • Phone (715) 552-4300 • FAX (715) 836-7683

The dispute over what is a significant discount, or what will create steerage into a network, is the issue being debated.

When OCI drafted the most recent version of the rule, plans that offered a 10% or lower discount were exempt from the requirements of managed care plans.

The justification for this standard is the generally accepted view in the industry that a 10% discount does not generate significant steerage of utilization to network providers. Again, the statute defines a policy as a managed care plan if it has any financial incentive. It is generally accepted industry actuaries that a discount approaching 20% for use of network providers is enough incentive to create significant steerage of utilization.

Currently, some insurers are asking that the rule be broadened to carve out plans that offer a 20% differential between in-network and out-of-network providers.

Conceptually this level of exemption violates the intent of the statute and, I believe, cannot be justified within the confines of the law. Again, any exemption is a stretch of the statutes. However, because the goal of a 10% threshold is meant to carve out plans that do not offer a significant incentive for in-network utilization, it seems justifiable.

In addition, a 20% threshold would exempt most non-HMO plans sold in Wisconsin.

This law was drafted recognizing that the possibility for abuse, and the need for consumer protection, does not exist with just HMOs, but in any plan that has a significant difference of cost for in and out of network utilization. It is a documented fact that point-of-service plans and preferred provider plans typically generate higher complaint ratios than HMOs.

Exempting some plans that are designed to steer policyholders to in-network providers would create an un-level playing field in the market and violate the spirit of the law.

I urge you to oppose any effort to broaden the exemption beyond what has been proposed by the Insurance Commissioner.

I appreciate your patience and attention to this issue. If you have any questions, please feel free to contact me at (715) 552-4330, ext. 134.

Sincerely,

Peter Farrow
Chief Operating Officer

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor
Connie L. O'Connell
Commissioner

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December 3, 1999

MW
This OK? What's left to do?
Jim

DEC 06 1999

THE HONORABLE RODNEY MOEN
STATE SENATOR
8 SOUTH CAPITOL
MADISON WI 53708

Re: Ins 9, Wis. Adm. Code

Dear Senator Moen:

After careful consideration of comments concerning the proposed administrative rules regarding managed care plans, I would like to recommend the following technical change to the rule:

Ins 9.42(1) Compliance program requirements. Amend the language to read:

Ins 9.42 Compliance program requirements. (1) All insurers writing managed care plans, preferred provider plans and limited service health organization insurers, except to the extent otherwise exempted under this rule or by statute, are responsible for compliance with ss. 609.15, 609.22, 609.24, 609.30, 609.32, 609.34, and 609.36, Stats., applicable sections of this subchapter and other applicable sections including but not limited to s. Ins 9.07. Insurers, to the extent they are required to comply with those provisions, shall establish a compliance program and procedures to verify compliance. Nothing in this section shall affect the availability of the privilege established under s. 146.38, Stats.

Thank you for the time you have spent working towards resolving the remaining issues on the managed care rule. If you have any questions about the proposed changes, please contact Eileen Mallow at 6-7843.

Sincerely,

Connie L. O'Connell

Connie L. O'Connell
Commissioner (by Rans)

cc: Randy Blumer
Guenther Ruch
Fred Nepple
Eileen Mallow

Wisconsin Association of Health Underwriters

Madison Office: 6441 Enterprise Lane Suite 102-A Madison, WI 53719-1139
Phone: (608) 277-1896 **Fax:** (608) 277-7685

Milwaukee Office: 1123 N. Water Street Milwuakee, WI 53202
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December 1, 1999

Commissioner Connie L. O'Connell
State of Wisconsin Office of the Commissioner of Insurance
121 E. Wilson St.
Madison, WI 53702

Dear Commissioner O'Connell:

I would like to thank you for taking the time to meet with Doug Johnson, Tim Byrne and me last week. I appreciate your department's efforts to address the concerns of all parties affected by Ins.9.

During our meeting, you indicated the OCI recognized differences between HMO's and PPO's and thus agreed to make modifications to the Quality Assurance provisions. We were pleased to hear this, and we support the suggestions and modifications to this provision as outlined in the draft presented to your office by the Center for Public Representation (dated November 4th, 1999). However, we are also concerned about the Access Standards provisions. As we discussed during our meeting, we are concerned how plans that use a PPO will be able to "demonstrate" they have met the rules as described in Ins. 9.34. We look forward to working with your office to find how insurers can realistically comply with the intent of the legislature and the rules.

We respectfully request your informal opinion on how PPO's may comply with Ins. 9.34 and Chapter 609.22 of the state statutes:

> Currently, those insurers that market PPO plans use providers directly contracted by the insurer, or they lease an independent network of providers. Both of these types of PPO arrangements simply contract with the provider for discounts and have no contractual relationship relative to the management of health care to the enrollee. These plans also offer varying levels of benefit differentials between in-network care versus out-of-network care. However, the common theme is that there is coverage outside of the network of providers, so that enrollees can seek care from any provider they wish.
>
> The PPO networks the insurers lease make efforts to contract with all types of providers, and in as many geographical areas of the state as their customers demand. There are some circumstances, however, that may raise compliance questions and your guidance will be helpful. For example, it is possible that not all types of providers are available in a certain geographical area within the network. Furthermore, it is the desire of PPO networks to

solicit providers, and provider groups, who meet certain standards such as; reasonable and normal hours of operation, waiting times for appointments, and after hours care. However, there maybe nothing in the relationship between the PPO network and the provider to prevent that provider from failing to provide these standards. In addition, there maybe nothing in the relationship to enforce such standards. For many of the PPO type plans marketed today, there is a reasonable potential that in some limited circumstances a provider within a network maybe unable to meet these standards.

We would like to request your informal opinion as to following:

Would your office consider an insurer in compliance with Ins. 9.34 if it: (1) submitted a certification indicating that benefits existed for care sought by enrollees outside of the network; and, (2) provided a statement by the insurer and/or the PPO network indicating the network uses its best efforts to contract with all types of providers, and with those providers that meet such standards as described above? If not, do you have any suggestions relative to demonstrating compliance of this provision? We are also in agreement in concept, but concerned with detail, regarding: hours of operation, waiting times for appointments and after hours care.

Thank you again for your interest. It would be most appreciated if we could get a response in the next week or so. If you need any additional information from me, please feel free to call me at 608-244-9227.

Sincerely,

Daniel J. Schwartzer

cc: Representative Gregg Underheim
Senator Rodney Moen
Douglas Q. Johnson, Wisconsin Merchants Federation, Conference of Retail Association

Managed Care Rule
PPOs

Suggested changes to Chapter 609
1/5/00

1. **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 only those providers that are managed, owned, under contract with or employed by the insurer offering the health benefit plan, such that benefits and coverage do not exist for services performed by non-participating providers.

2. **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 enrollees, for consideration other than predetermined periodic fixed payments, either comprehensive health care services or a limited range of health care services performed by either providers participating in the plan, or by non-participating providers.

3. **609.10 Standard plan required. (1)** (a) Except as provided in subs. (2) to (4), an employer that offers any of its employees a health maintenance organization 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.
(b) .....

4. **609.22 (5)** SECOND OPINION. A managed care plan and preferred provider plan shall provide an enrollee with coverage for a 2nd opinion from another participating provider.

5. **609.22 (6)** EMERGENCY CARE. Notwithstanding s. 632.85, if a managed care plan and preferred provider plan provides coverage of emergency services, with respect to covered benefits, the managed care plan and preferred provider plan shall do all of the following:

6. **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 and a preferred provider plan shall, with respect to covered benefits, provide coverage to an enrollee.....

7. **609.30 Provider disclosures. (1)** PLAN MAY NOT CONTRACT. A managed care plan and a preferred provider 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 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 and a preferred provider plan may not penalize or terminate the contract of a participating provider.....

8. **609.36 Data systems and confidentiality. (1)** INFORMATION AND DATA REPORTING. (a) A managed care plan and preferred provider plan shall provide to the commissioner information related to all of the following:
The structure of the plan.
Health care benefits and exclusions.
Cost-sharing requirements.
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 and preferred provider 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.

9. **609.38 Oversight.** The office shall perform examinations of insurers that issue limited service health organizations, preferred provider plans and managed care plans consistent with ss 601.43 and 601.44. The commissioner shall by rule develop standards for compliance with the applicable requirements under this chapter, that take into account the differences in the marketplace between limited service health organizations, preferred provider plans and managed care plans.

10. **609.655 Coverage of certain services provided to dependent students. (1)** In this section:
(a) "Dependent student" means an individual who satisfies all of the following:
1. Is covered as a dependent child under the terms of a policy or certificate issued by a managed care plan or preferred provider plan insurer.
2. Is enrolled in a school located in this state but outside the geographical service area of the managed care plan or preferred provider plan.
.....
(2) If a policy or certificate issued by a managed care plan or preferred provider plan insurer provides coverage of outpatients services.....

(3) Except as provided in sub. (5), a managed care plan or preferred provider plan shall provide coverage for all .....

Wisconsin Association of Health Underwriters

Madison Office: 6441 Enterprise Lane Suite 102-A Madison, WI 53719-1139
Phone: (608) 277-1896 Fax: (608) 277-7685

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Phone: (414) 276-7377 Fax: (414) 276-7704

Summary of the Suggested Changes to Chapter 609

January 5th 2000

The intent of the suggested changes to Chapter 609 was to correct the existing statutes where they did not appropriately recognize the differences which exist between managed care plans and preferred provider plans. From the beginning of the debate, the argument has been that because of the failure to recognize these differences, there are provisions of this statute (and ultimately Ins.9) that are impossible for preferred provider plans to comply with. These provisions relate to quality assurance and access standards, section 609.32 and 609.22 respectively.

The problem lies not only within those sections, but also within the definitions of managed care plans, preferred provider plans and health maintenance organizations. Accordingly, the suggested changes attempt to correct the two described sections, as well as the definitions. In addition, the rules promulgated by the OCI include provisions to include a medical director only when "the plan assumes direct responsibility" for protocols and utilization management procedures (Ins 9.40 (3)(b)(2)). Therefore, because the operation of a preferred provider plan is not to direct protocol, and because the definitions section has changed, we are leaving preferred provider plans out of the Clinical decision/Medical Director provision (609.34).

These modifications attempt to make very narrow changes to exclude preferred provider plans from the provisions which are impossible to comply with. It is not the intent to exclude preferred provider plans from Chapter 609 altogether. Rather, the suggested changes ensure the continued inclusion into the remaining sections of this statute. Specifically, preferred provider plans are included in; Indication of operation (609.03), Primary provider and referrals (609.05), Grievance procedure (609.15), Reports of disciplinary action (609.17), Rules for preferred provider and managed care plans (609.20), parts of the Access standards (609.22 (5) & 609.22 (6)), Continuity of care (609.24), Provider disclosures (609.30), a revision of Quality promotion (609.33), Data systems and confidentiality (609.36), Oversight (609.38), Optometric coverage (609.60), Coverage for court-ordered services for the mentally ill (609.65), Coverage of certain services provided to dependent students (609.655), Chiropractic coverage (609.70), Adopted children coverage (609.75), Coverage of breast reconstruction (609.77), Coverage of treatment for the correction of temporomandibular disorders (609.78), Coverage of hospital and ambulatory surgery (609.79), Coverage of mammograms (609.80), Coverage related to HIV infection (609.81), Coverage without prior authorization for emergency medical condition treatment (609.82), Coverage of drugs and devices (609.83), Experimental treatment (609.84), and, Coverage of lead screening (609.85). As for the remaining provision within Chapter 609, please note that preferred provider plans were never originally included in 609.91 thru 609.935.

The following is an explanation as to the suggestions and how they relate to the intent of these changes:

1. To begin with, it is important to recognize that preferred provider plans do not "manage" care, and thus should not be included in the definition of managed care. However, and more importantly, a further explanation of this definition is needed in order to exclude preferred provider plans from quality assurance and access standards. (Please note that in the first draft of these changes, there was an attempt to further clarify the definition of health maintenance organizations, but the drafter appeared to have problems in making these changes. Relative to this definition, we will not argue. However, there must be an expansion of the definition of managed care in order to correct the problems within the statutes. We would like to work with the drafter to accomplish this) In LRB-4087/P1, this change has not been made.

2. This change, as described in #1 above, is to correct the problems within the definitions section. In LRB-4087/P1, this change was made as requested in SECTION 5.

3. Because a preferred provider plan provides exactly what 609.10 and Act 9 requires, which is to offer a standard base plan where enrollees can use any provider, it was redundant to leave preferred provider plans in this provision. Therefore, we made suggestions to remove preferred provider plans from this section, and SECTIONs 6 thru 10 in LRB-4087/P1 expanded the removal to the language in Act 9 appropriately.

4. Preferred provider plans have the ability to comply with this specific provision within the access standards. Because of #1 and #2 above, this change is necessary in order to include these plans within this provision. (Please note that this request was not made in the first draft, and therefore not included in LRB-4087/P1).

5. Same as #4 above.

6. Preferred provider plans have the ability to comply with the Continuity of Care provisions. Because of #1 and #2 above, this change is necessary in order to include these plans within this provision. SECTIONs 12 thru 18 of LRB-4087/P1 make these changes.

7. Preferred provider plans have the ability to comply with the Provider Disclosures provisions. Because of #1 and #2 above, this change is necessary in order to include these plans within this provision. SECTIONs 19 thru 20 of LRB-4087/P1 make these changes.

8. Preferred provider plans have the ability to comply with the Data Systems and Confidentiality provisions. Because of #1 and #2 above, this change is necessary in order to include these plans within this provision. SECTIONs 21 thru 22 of LRB-4087/P1 make these changes.

9. This suggestion, as outlined in the first draft, attempted to include preferred provider plans into this provision. SECTION 23 of LRB-4087/P1 raised concerns about trying to repeal this provision, which was not the intent. Therefore, this revised suggestion includes preferred provider plans in this provision, but requires the OCI to develop rules that are applicable to the differences which exist between managed care plans and preferred provider plans, and how those rules affect the marketplace.

10. Preferred provider plans have the ability to comply with Coverage of certain services provided to dependent students. Because of #1 and #2 above, this change is necessary in order to include these plans within this provision. (Please note that by error, this request was not made in the first draft, and therefore not included in LRB-4087/P1).

Additional comments:

SECTION 11 of LRB-4087/P1, made changes which we did not request. However, we agree and understand why it was necessary to make these changes, as discussed in #3 above.

SECTION 24 of LRB-4087/P1 makes changes to include preferred provider plans in the Coverage of mammograms provisions due to the changes within the definitions. Our first draft of suggested changes did not include this request, which was an oversight. Preferred provider plans should be included in this provision and SECTION 24 appropriately accomplishes this.

609.32 - While preferred provider plans cannot "assure" quality of health care and while we do not believe these plans have the ability to control quality of health care, there was some general agreement with the Center for Public Representation's November 4th draft language of this issue. Therefore, we would be willing to continue discussions with CPR and any other interested party relative to the promotion of quality among network providers.

State of Wisconsin
Office of the Commissioner of Insurance

Fact Sheet on Managed Care Consumer Protections in Wisconsin

The Wisconsin Office of the Commissioner of Insurance has prepared the following information on managed care consumer protections in Wisconsin. If you have questions or problems with your managed care plan, please contact:

Office of the Commissioner of Insurance
P. O. Box 7873
Madison WI 53707-7873
(608) 266-0103 (in Madison)
1-800-236-8517 (outside Madison)

During the past year, Wisconsin has enacted legislation that provides additional safeguards for persons whose health insurance is delivered through a managed care plan. When combined with existing statutes, Wisconsin offers significant consumer protections. And in some cases, the protections extend to all health insurance products offered in Wisconsin.

Q. How is managed care defined?

A. By law, a managed care plan is defined as any health benefit plan that requires or creates incentives for an enrollee to use providers that are owned, managed, or under contract with the insurer offering the health benefit plan.

Under this definition, health insurance products such as preferred provider plans (PPPs), health maintenance organizations (HMOs), and most network type of health plans would be considered managed care and would be required to conform to the consumer protection laws. Health insurance products known as limited service health organizations, or LSHOs, that cover benefits for specific services such as dental-only or vision-only are also subject to some provisions of this law.

Some self-insured plans, also called ERISA policies, are exempt from any state insurance regulation, including the managed care provisions. To determine if you are covered by an ERISA plan, contact your employer.

Q. When did these changes go into effect?

A. Most of the new changes went into effect with policies that renewed on or after January 1, 1999.

Q. What consumer protections are offered?

A. The consumer protections covered in Wisconsin law include:

Grievance process--If you disagree with your managed care plan's decisions, you have the right to file a grievance with the plan and have it resolved within 30 days. If you have an urgent health care situation, the grievance must be resolved more quickly. The plan must give you written information about the process for filing a grievance.

Access to providers--A managed care plan must have enough providers available to give you a reasonable choice of providers. Plans are not required to permit you to see any provider you wish.

Standing referral to specialists--If warranted by your health condition, a managed care plan must give you a standing referral to a specialist provider. The plan must also tell you under what conditions a standing referral will be granted and how to apply.

Second opinions--Every managed care plan must cover a second opinion from another provider within the managed care plan network.

Emergency care--Every health benefit plan offered in Wisconsin that covers emergency care, including managed care plans, must cover services required to stabilize a condition that a reasonably prudent layperson would consider to be an emergency, without prior authorization. Health plans are permitted to charge a reasonable copayment or coinsurance for this benefit.

Continuity of care--If your managed care plan represented a primary care physician (defined as internal medicine, pediatrics or family practice) as being available during your open enrollment period, they must make the physician available to you at no additional cost for the entire plan year. A specialist provider must be made available for the lesser of the course of treatment or 90 days. If you are in your second trimester of pregnancy, the provider must be available through post-partum care. The exceptions to this statute are for a provider who is no longer practicing in the managed care plan service area or who was terminated from the plan for cause.

Gag clauses--A managed care plan may not limit your health care provider's disclosure of information regarding all of your treatment options. However, this does not mean that all treatment options are necessarily covered by your managed care plan. If you are unsure about whether a particular treatment is covered, you should contact your managed care plan directly.

Quality assurance plans--All managed care plans are required to develop and implement a quality assurance plan.

Q. What other protections are available to me as a health care consumer?

A. If your health insurance plan limits coverage of an experimental treatment, procedure, drug or

device, the insurer is required to clearly disclose those limitations in the policy. Additionally, the insurer must have a process for you to request a timely review of a denied experimental treatment.

If your health insurer limits coverage of drugs to those on a pre-approved list, often called a formulary, the insurer must have a process for your physician to present medical evidence to request coverage of a drug that is not on the approved list.

Q. What do I do if I am unhappy with my managed care plan's decisions?

A. First, you should discuss your concerns with your managed care plan. Make sure you keep good notes of the discussions you have. If you are unable to resolve your concerns through discussion, you have the right to file a grievance with the plan. The plan must provide you with information on how to file a grievance.

If, at any time, you are unhappy with your plan's decision, you have the right to file a complaint with the Office of the Commissioner of Insurance (OCI). You may contact the office at the address listed on the front page.

Q. How do I get more information?

A. OCI publishes a brochure specific to managed care plans, *Consumer's Guide to Managed Care Health Plans in Wisconsin*. It is available by calling our toll-free number or on the agency's Web site.

Feedback and Questions

Your input is always welcome! Send your comments and suggestions to: OCI Public Information Officer, P.O. Box 7873, Madison,WI 53707-7873, or information@oci.state.wi.us (please include your name, phone number, and e-mail address).

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Last Updated: May 20, 1999

State of Wisconsin Office of the Commissioner of Insurance
121 East Wilson Street
Madison, Wisconsin 53702
(608) 266-3585, Madison; (800) 236-8517, statewide; (800) 947-3529 (TDD);
(608) 266-9935, fax

State of Wisconsin
Office of the Commissioner of Insurance

Fact Sheet on Continuation and Conversion in Health Insurance Policies

In 1980, the Wisconsin Legislature passed a law (s. 632.897, Wis. Stat.) relating to continuation and conversion rights in health insurance policies. The federal government passed a law in 1986 that also gives certain individuals the right to continue health care coverage. In some ways the laws are similar, but in other ways they are very different. The federal law does not preempt state law, and both laws may apply to a policy. In cases where the federal and state laws differ, it is the opinion of the Office of the Commissioner of Insurance that the law most favorable to the insured is the one that applies.

Federal Law

In 1986, the federal government enacted a law that gives many persons who would otherwise lose their group health coverage the right to continue coverage under the group plan. This law applies to both insured plans and self-funded, employer-sponsored plans, except that it does not apply to church plans, plans covering less than 20 employes, and plans covering federal employes. This law is frequently referred to as "COBRA."

Under the federal law, employes who terminate employment for any reason other than gross misconduct, those whose hours are reduced, and dependents of these employes may continue the group coverage for up to 18 months. Dependents may continue coverage for up to 36 months if they lose coverage for any of the following reasons: death of the employe, divorce from the employe, the dependent has reached the maximum age under the policy, or the employe becomes eligible for Medicare. Disabled employes can continue coverage for up to 29 months.

State law runs concurrent with federal law in cases where both laws apply. There are differences between the two laws, and persons may have to comply with both.

Wisconsin Law

The Wisconsin law applies to insured group plans that provide hospital or medical expenses. In the case of divorce or annulment, the law applies to individual policies that offer the same type coverage.

The law does not apply to policies that cover only specified diseases or accidental injuries.

The law:

- Gives most employes and their dependents who have been continuously covered under a group policy for at least three months the right to continue their group hospital and medical coverage or to convert to an individual policy providing similar benefits if they would otherwise lose eligibility for the group policy.

- Gives spouses who would otherwise lose their coverage because of divorce or annulment the right to continue coverage under the group policy or convert to an individual policy providing similar benefits.

- Provides that the person continuing group coverage or converting to an individual policy must pay the entire premium for the coverage.

The law does not apply to most group policies issued outside Wisconsin unless more than 25% or 150 people insured, whichever is less, are Wisconsin residents, or which are fully self-funded by an employer and subject to federal law.

Note: The right to continue current coverage or to convert to an individual policy is not extended if eligibility for coverage terminates due to discharge for misconduct shown in connection with employment.

Commonly Asked Questions About Wisconsin's Law

Who has continuation and conversion rights?

- A former spouse whose coverage ends because of divorce or annulment;

- A group member who is no longer eligible for coverage under a group policy unless eligibility is lost because of discharge for misconduct;

- The dependents of a group member who is no longer eligible for coverage under a group policy unless eligibility is lost because of discharge for misconduct; and

- The covered spouse or dependent of a group member who dies.

How long may a person continue group coverage after eligibility would otherwise end?

A person may continue group coverage until:

- Residence outside Wisconsin is established; (conversion rights still apply).

- Premiums are not paid;

- The person becomes eligible for similar coverage under another group policy;

- In the case of a divorced person who is continuing under a former spouse's coverage, the former spouse loses eligibility for the group policy; (conversion rights still apply) or

- 18 months of continued group coverage elapse, and the insurance company requires conversion to an individual policy.

Is it possible to continue coverage under a former employer's plan even if one works for a different employer?

Yes, although the coverage may be terminated under any of the circumstances listed above.

If a person becomes eligible for similar group coverage under another group policy, may the person continue previous coverage until the end of any waiting period for preexisting conditions under the new policy?

Yes, if the effect of the waiting period would be to reduce coverage to the point where it is not similar. Premiums would have to be paid for both coverages and benefits might not be duplicated. Also, the continued coverage could be terminated under any of the other circumstances listed above.

In the event of a divorce or annulment, what rights are provided for the spouse who loses eligibility for group coverage?

If insured under a group policy, the terminated spouse may choose between converting to an individual policy or continuing group coverage. The employer may require the terminated spouse to take single group coverage, rather than family, and to pay the entire premium for the coverage. If insured under an individual policy, the spouse of the insured is eligible to obtain an individual policy in his or her name.

Note: There are now special laws in effect for those who work for small employers (2-25 employes). Contact the Insurance Commissioner's office for more information.

Do continuation or conversion rights extend to people eligible for Medicare?

An insurer must offer continued group coverage, but it need not duplicate benefits paid by medicare. An insurer is not required to offer or keep in force conversion policies if Medicare benefits and the conversion policy benefits result in overinsurance and the insurer has filed its overinsurance standards with the Commissioner.

Do continuation or conversion rights extend to people whose work hours are reduced or who are on strike?

Yes, because continuation or conversion rights are extended to people who would otherwise lose eligibility for coverage under the group policy. However, if an entire group policy is cancelled (which could happen during a strike), continuation is no longer possible and only conversion rights remain.

What type of conversion policy must an insurer offer?

An insurer must offer at least:

- Coverage similar to that offered under the previous policy, or
- A high-limit comprehensive policy, or
- A choice among three different plans, including basic coverage and two major medical expense policies.

How much must one pay for continuation or conversion coverage?

The cost for continued group coverage is the amount paid by a group member plus any amount paid by the employer for each member.

Under federal law employers may charge up to 102% of the group premium to cover the additional administrative costs.

The insurer issuing the policy determines the cost of conversion policies, and the cost is much higher than the cost of group coverage.

Who is responsible for notifying people of their rights to continuation or conversion?

The employer is required to provide notice in the case of group coverage.

If a couple is covered under an individual (not group) policy and coverage of one spouse ends because of divorce or annulment, the insurer is responsible for giving notice of the right to convert.

What happens if someone is not notified of his or her rights?

Coverage continues if the required premium is paid. If coverage terminates, the aggrieved party may have a basis for a civil action against the employer, former spouse or insurer. The statute itself does not make another party responsible for a terminated insured's medical expenses.

What is meant by "discharge for misconduct shown in connection with his or her employment?"

The statute does not explain this. The courts have decided cases involving the question of misconduct in connection with unemployment compensation cases and might use the same parameters when determining if a person is eligible for continuation/conversion rights. That, however, is up to the courts to decide. The Commissioner of Insurance does not have authority to decide such questions.

Are continuation or conversion rights available if a group policy terminates because an employer goes out of business?

Continuation rights are not available because no group policy exists.

The right to convert to an individual policy providing reasonably similar benefits still applies.

How does an employe's eligibility for family or medical leave through an employer relate to his or her continuation and conversion rights?

Wisconsin law requires employers who employ 50 or more employes on a permanent basis to allow employes who meet certain criteria the right to take family or medical leave. If an employe is on such leave, the employer must maintain group health insurance coverage under the same condition that applied prior to the leave. However, the employe is required to make the same premium contributions that he or she would have made if not on leave. An employe who is unable to return to work at the end of the family or medical leave is then eligible for continuation. The 18 months of eligibility for continuation begins when the family or medical leave ends or when the health insurance coverage would otherwise terminate, not when the family or medical leave began.

Where to Go For Help

For questions about Wisconsin law, contact:

Office of the Commissioner of Insurance
121 E. Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-0103
1-800-236-8517 (Outside Madison)

For questions about the federal law, **Private employers** may contact:

U.S. Department of Labor
Division of Technical Assistance
Pension and Welfare Benefits Administration
200 Constitution Avenue, N.W., Room N-5658
Washington, DC 20210
(202) 219-7222 Ext. 3016

For information on filing a complaint with the Insurance Commissioner's Office, call:

Telephone Message System
(608) 266-0103 (In Madison)
or
1-800-236-8517 (Outside Madison)

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS.

For your convenience, a complaint form is included in OCI's Web Site.

Feedback and Questions

Your input is always welcome! Send your comments and suggestions to: OCI Public Information Officer, P.O. Box 7873, Madison,WI 53707-7873, or information@oci.state.wi.us (please include your name and e-mail address).

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Last Updated: June 9, 1997

State of Wisconsin Office of the Commissioner of Insurance

Wisconsin Managed Care Patients Have the Best Bill of Rights in the Country

Provisions of 1997 Wisconsin Act 237 (effective 1/1/99):

Adequate and Accessible Providers

- Patients have access to sufficient numbers and types of health care providers to meet their needs.
- Patients have adequate choice among participating providers.
- Participating providers are accessible and qualified.
- Patients may select their own primary provider from among their plan's primary care physicians or any other participating provider authorized to serve as a primary provider.
- Managed care plans must update their primary provider lists regularly and ensure that there are enough primary providers accepting new patients to meet patients' needs.

Specialist Provider Access

- Patients may request a standing referral to a specialist.
- Patients may receive primary care services from a specialist.
- Patients receive information describing the referral procedure.

Second Opinion Coverage

- Coverage is provided for a second opinion received from another participating provider.

Emergency Care Coverage (effective 11/1/98)

- Patients may go to the emergency room without prior authorization and will have their services covered if a "prudent layperson" would have considered their symptoms an emergency.

Telephone Access

- Patients have telephone access to the plan for sufficient time during business and evening hours to ensure access to routine health care services.
- Patients have 24-hour telephone access to the plan or to a participating provider for emergency care.

Services for Underserved Populations

- Access issues for patients who are members of underserved populations are addressed.
- Patients who don't speak English have access to translator services.

Continuity of Care Protections

- Patients receiving services from a provider listed on the plan's provider list will have their services paid for regardless of whether the provider was a participating provider at the time the services were received.
- Patients receiving services from a specialist who terminates from the plan will have their services paid for through the remainder of their course of treatment or for 90 days.
- Pregnant patients in their second trimester may continue to see their OB/GYN throughout postpartum care for themselves and their infants even if their OB/GYN terminates from the plan.

"Gag Clauses" Prohibitions

- Patients are ensured that their providers are free to discuss with them all treatment options.

Quality Assurance Standards

- Patients benefit from required quality assurance plans to identify, evaluate and remedy problems related to access to care, continuity of care and quality of care.

Provider Selection and Evaluation Provisions

- Patients benefit from a required process for initial and ongoing review and approval of providers. Criteria for reevaluating providers includes patient clinical outcomes and patient satisfaction.

Physician Medical Directors

- Only physicians may serve as a managed care plan medical director.

Confidentiality Protections

- Patient confidentiality is ensured through written policies and procedures for handling medical records and other patient communications.

Drugs and Devices/Experimental Treatment Provision

- Providers have a venue for requesting coverage of a drug or device not routinely covered by the plan. The process includes timelines for both urgent and non-urgent review.

- Patients are provided with detailed information on coverage of experimental treatments and must receive an answer for a request for coverage within five business days.

Agency Oversight

- The Office of the Commissioner of Insurance (OCI) examines managed care plans to ensure compliance with the managed care law.

Wisconsin HMOs Work for Wisconsin

- 24 HMOs care for over 1.6 million Wisconsin health care consumers.

- For the first quarter of 1999, the profit margin of Wisconsin HMOs was –0.22%. The combined net loss was $1.6 million. Nevertheless, Wisconsin HMO per member/per month premiums continue to increase at a lower rate than medical expenses. During the same period, the medical expense ratio increased to 91.04% and the administrative expense ratio decreased to 10.23%.

- Wisconsin HMO patients accessed health care services approximately 27 million times during 1997, but only filed grievances at a rate of 1/100 of one percent. A recent report by the Office of the Commissioner of Insurance (OCI) showed the rate of HMO grievances declined in 1998. Wisconsin HMO consumers are among the best protected in the nation, according to a report by Families U.S.A., a health care consumer watchdog group. Wisconsin HMOs' grievance systems, in particular, were cited as superior to most of the rest of the nation.

- HMO surveys consistently show that Wisconsin HMO patients are highly satisfied with their health care. An independent survey conducted for the Department of Employe Trust Funds (DETF) shows on average, 92% of surveyed state employees would recommend their HMO to family and friends.

- Wisconsin HMOs provide health care to nearly 75,000 Wisconsin state employees and to nearly 185,000 Wisconsin Medicaid recipients. HMO coverage for state employees saved taxpayers as much as $203 million from 1990 through 1994. The Wisconsin Medicaid/HMO program saved the state over $100 million between 1984 and 1995.

- HMOs contributed to Wisconsin leading the nation in providing more health insurance to more people by making available in the market, affordable, comprehensive health care plans.

Association of Wisconsin HMOs, 2 E. Mifflin St., Ste. 701, Madison, WI 53703 P: 608-255-8599, F: 608-255-8627

Wisconsin HMOs Work for Wisconsin

- The Association of Wisconsin HMOs' 23 member health plans care for over 1.65 million Wisconsin health care consumers.

- From beta blocker treatment for heart attack patients to breast cancer screening and childhood immunizations, Wisconsin HMOs score above the national average on key quality measures, according to a recent Association HEDIS measure survey.

- The independent Health Risk Management (HRM) QualityFIRST Index recently ranked Wisconsin third in the nation for health care quality. Wisconsin ranked in the top five in 1998.

- For the second quarter of 1999, the profit margin of Wisconsin HMOs was –1.28%. The combined net loss was $18.6 million. Nevertheless, Wisconsin HMO per member/per month premiums continued to increase at a lower rate (6.5%) than medical expenses (8.1%). During the same period, the medical expense ratio increased to 92.16% and the administrative expense ratio increased slightly to 10.49%.

- Wisconsin HMO patients accessed health care services approximately 27 million times during 1997, but only filed grievances at a rate of 1/100 of one percent. A recent report by the Office of the Commissioner of Insurance (OCI) showed the rate of HMO grievances declined in 1998. Wisconsin HMO consumers are among the best protected in the nation, according to a report by Families U.S.A., a health care consumer watchdog group. Wisconsin HMOs' grievance systems, in particular, were cited as superior to most of the rest of the nation.

- HMO surveys consistently show that Wisconsin HMO patients are highly satisfied with their health care. An independent survey conducted for the Department of Employe Trust Funds (DETF) shows on average, 92% of surveyed state employees would recommend their HMO to family and friends.

- A Legislative Audit Bureau report found that Wisconsin's policy of encouraging state employees to receive health care through HMOs "may have saved the state (taxpayers) as much as $203 million . . . from 1990 through 1994."

- The Department of Health and Family Services (DHFS) has estimated that the Wisconsin Medicaid/HMO program saved the state over $100 million in health care costs between 1984 and 1995. Just as important, DHFS has documented that Wisconsin's Medicaid recipients are receiving better health care through HMOs than they were in the more expensive, old style fee-for-service Medicaid program.

- For the third year in a row, HMOs contributed to Wisconsin leading the nation in providing more health insurance to more people by making available in the market, affordable, comprehensive health care plans. In the third quarter of 1998, 16.1% of Americans nationally were uninsured. For the same period, Wisconsin's uninsured rate was 8%. That is .5% lower than the previous year and the second lowest uninsured rate in the country.

Association of Wisconsin HMOs, 2 E. Mifflin St., Ste. 701, Madison, WI 53703 P: 608-255-8599, F: 608-255-8627

Customer satisfaction high with Wisconsin HMOs

By BETH ZURBUCHEN
Report for The Madison Business Journal

If you work in Dane County, chances are you have health insurance through a managed care plan. The latest national health quality reviews and state satisfaction surveys should reinforce your health care experience that HMOs work to provide the health care and services you and your family need and want.

In 1999, 1.6 million people were enrolled in one of 24 HMO plans in Wisconsin. This represents 20 percent of HMO coverage statewide. The numbers increase dramatically when you look at just Dane County. The National Research Corporation's Health Care Market Guide Survey shows 70.9 percent of Madison's health care market belongs to HMOs. That number jumps to 89 percent when all forms of managed care are included.

This must mean HMOs are meeting the needs of their patients. While surveys consistently show that eight out of ten people in Wisconsin are satisfied with their HMO, in Dane County, satisfaction levels are even higher.

The Department of Employee Trust Funds (DETF) compiles annual health plan satisfaction data from state workers. Nearly 61,000 state employees and their family members are enrolled in an HMO as are 14,000 retired state workers.

The 1998 Wisconsin health plan report card shows 92 percent of state employees would recommend their HMO to family and friends. Nearly identical results were found in 1997 when 91 percent of state workers said they would recommend their HMO. As far as recommending their primary care physician, 94 percent would do so while 91 percent of state workers would recommend their specialists to family and friends.

The endorsement levels sparkle when Wisconsin's numbers are compared to satisfaction figures compiled by Consumer Reports in its August 1999 issue ranking the nations 54 largest HMOs. Those numbers show 57 percent of the respondents said they were completely satisfied or very satisfied with their health plan. Consumer Reports also writes if you have a choice in HMOs "pay attention to how satisfied others are. For most plans we have rated, there is little change in their satisfaction scores from year to year; those with a high score are probably doing something right."

Reviewing national benchmarks from the four HMOs doing business in Dane County, proves they are "doing something right."

The National Research Corporation rated Dean Health Plan as one of the state's top HMOs with 96.2 percent of members indicating they would recommend Dean to friends and family. Dean Health Plan has also earned a one-year accreditation from the National Committee for Quality Assurance (NCQA).

Employers, unions and health plans developed the NCQA standards as a way to measure the quality of HMOs. Those quality assessments include physician credentials, preventive care, quality improvement and members' rights and responsibilities. Accreditation is a national HMO quality seal of approval.

In 1998, Group Health Cooperative of South Central Wisconsin (GHC-SC) was recognized by *U.S. News and World Report* as the 13th best HMO in the country. The news magazine rates 271 health plans annually. GHC-SC is Madison's oldest HMO and in 1995, was the first Wisconsin HMO to receive a full three-year NCQA accreditation. GHC-SC is currently working to extend accreditation through April 2002.

In September 1998, *Newsweek* ranked Physicians Plus Insurance Corporation (PPIC) 25th among all U.S. HMOs for keeping members healthy, treating illnesses and managing chronic conditions for adults and children. Also in 1998, *U.S. News and World Report* ranked PPIC as the 32nd best HMO in the United States. PPIC has been evaluated by NCQA and expects to receive accreditation by the end of August.

Unity Health Plans, based in Sauk City, is one of the nation's first rural-based HMOs. Every month, Unity talks with 400 of its patients to get an ongoing look at their quality of care. In June of 1999, 94 percent expressed satisfaction with their health care. Unity is also working on receiving NCQA accreditation in the next two years.

When you look inside an HMO you see that managed health care is about preventive medicine. On July 28, 1999, NCQA released what's called its Quality Compass.

From beta blocker treatment of heart patients to breast cancer screening and childhood immunizations, Wisconsin HMOs score well above the national average proving we set and meet our high expectations for health care delivery. By focusing on prevention and early intervention, Wisconsin HMOs are helping create a healthier population.

For example, Wisconsin HMO childhood immunization rates are more than 75 percent, compared to about 65 percent nationwide.

Our ongoing effort to keep children free from illness is why HMOs cover the doctor visit and immunizations. Traditional fee-for-service insurance or other managed care and prevention services often require large co-pays if they cover immunizations at all.

This latest NCQA review shows once again, Wisconsin HMOs are committed to better health care through preventive programs designed to protect patients from illness.

A national consumer watchdog group, Families USA, reports Wisconsin HMO members are among the best protected in the nation. That protection includes the right to file a grievance if you are not satisfied with your doctor or with a recommended treatment. Most grievances must be resolved within 30 days, and urgent care grievances must be resolved within four working days.

Wisconsin HMOs want to get it right the first time. Information from the Wisconsin Office of the Commissioner of Insurance (OCI) shows for every 10,000 Wisconsin HMO enrollees, there were 32 grievances in 1998 involving any aspect of the health plan and administration. That number is down from a year earlier, even though there were more than 90,000 new HMO patients.

Because health care is intensely personal, each Wisconsin HMO is committed to listening and responding to patients' comments and concerns. This commitment and the continuing effort to provide high quality health care while keeping costs down, makes Wisconsin HMOs work for patients.

Beth Zurbuchen, is communications director for the Association of Wisconsin HMOs.

NCQA's 1999 Quality Compass

PREVENTATIVE MEASURES	1998 WISCONSIN HMOS' 1998 AVERAGE	NATIONAL AVERAGE
Advice to Quit Smoking	68.5%	62.5%
Beta Blocker Treatment	83.0%	79.9%
Breast Cancer Screening	79.1%	72.2%
Cervical Cancer Screening	78.1%	69.9%
Childhood Immunizations	75.4%	64.8%
Diabetic Eye Exams	54.2%	40.9%
1st Trimester Prenatal Care	89.0%	83.6%