2005 DRAFTING REQUEST

Bill

Received: **02/10/2006**

Received By: **chanaman**

Wanted: **As time permits**

Identical to LRB:

For: **Dan Kapanke (608) 266-5490**

By/Representing:

This file may be shown to any legislator: **NO**

Drafter: **chanaman**

May Contact:

Addl. Drafters:

Subject: **Insurance - health**

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Kapanke@legis.state.wi.us**

Carbon copy (CC:) to: **richard.sweet@legis.state.wi.us**
joyce.kiel@legis.state.wi.us

Pre Topic:

No specific pre topic given

Topic:

Defined network plans

Instructions:

See Attached--same as -4455, but that should have been a /p draft

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Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	chanaman 02/10/2006	jdyer 02/13/2006		_____ _____			
/P1	chanaman 02/20/2006	jdyer 02/20/2006	jfrantze 02/13/2006	_____ _____	sbasford 02/13/2006		
/1			pgreensl 02/20/2006	_____ _____	lnorthro 02/20/2006	lnorthro 02/20/2006	

FE Sent For: none

<END>

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/?	chanaman 02/10/2006	jdyer 02/13/2006		_____ _____		PAS - please jacket for Kapanke office	
/P1		1 2/20 jld	jfrantze 02/13/2006	_____ _____	sbasford 02/13/2006		

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<END>

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By/Representing:

This file may be shown to any legislator: **NO**

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May Contact:

Addl. Drafters:

Subject: **Insurance - health**

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Kapanke@legis.state.wi.us**

Carbon copy (CC:) to: JOYCE KIEL & DICK SWEET AT LRB COUNCIL

Pre Topic:

No specific pre topic given

Topic:

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Instructions:

See Attached--same as -4455, but that should have been a /p draft

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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	chanaman	/p1 2/13 jld	2/13	2/13			

FE Sent For:

<END>

-4636/P1

2005 – 2006 LEGISLATURE

LRB-~~4275/P2~~
CMH&PJK:jld:rs

stays

Companion - no changes

d-note

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

Mon

regen cart

AN ACT ***to repeal*** 611.67 (1) (d) and 628.36 (2m) (a) 3.; ***to renumber*** 609.01 (4), 609.35 and 609.82; ***to amend*** 51.20 (7) (am), 149.10 (8m), 150.84 (5), 600.03 (23g) (a), 601.47 (3), 632.745 (15), 632.84 (3), 632.86 (1) (a), 632.895 (14) (d) 3. and 635.02 (8); and ***to create*** 601.47 (2m), 609.01 (4g), 609.20 (3), 609.20 (4), 609.22 (1m), 609.22 (9), 609.23, 609.35 (1) and 609.82 (2) of the statutes; **relating to:** defined network plans.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a later version.

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

SECTION 1. 51.20 (7) (am) of the statutes is amended to read:

51.20 **(7)** (am) A subject individual may not be examined, evaluated or treated for a nervous or mental disorder pursuant to a court order under this subsection unless the court first attempts to determine whether the person is an enrollee of a

health maintenance organization, as defined in s. 609.01 (2), limited service health organization, as defined in s. 609.01 (3), or preferred provider plan, as defined in s. ~~609.01~~ 600.03 (37m), and, if so, notifies the organization or plan that the subject individual is in need of examination, evaluation or treatment for a nervous or mental disorder.

SECTION 2. 149.10 (8m) of the statutes is amended to read:

149.10 **(8m)** "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~ 600.03 (37m).

SECTION 3. 150.84 (5) of the statutes is amended to read:

150.84 **(5)** "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~ 600.03 (37m).

SECTION 4. 600.03 (23g) (a) of the statutes is amended to read:

600.03 **(23g)** (a) Contracts with a health maintenance organization, as defined in s. 609.01 (2), limited service health organization, as defined in s. 609.01 (3), or preferred provider plan~~, as defined in s. 609.01,~~ to provide health care services.

SECTION 5. 601.47 (2m) of the statutes is created to read:

601.47 **(2m)** The commissioner shall prepare and publish a guide that describes out–of–network coverage for all defined network plans and distribute it in a manner that the commissioner determines. The cost of publication and distribution may be paid from the appropriation under s. 20.145 (1) (g).

SECTION 6. 601.47 (3) of the statutes is amended to read:

601.47 **(3)** FREE DISTRIBUTION. The commissioner may furnish free copies of the publications prepared under subs. (1) ~~and~~, (2), and (2m) to public officers and libraries in this state and elsewhere. The cost of free distribution shall be charged to the appropriation under s. 20.145 (1) (g).

1 **SECTION 7.** 609.01 (4) of the statutes is renumbered 600.03 (37m).

2 **SECTION 8.** 609.01 (4g) of the statutes is created to read:

3 609.01 **(4g)** Notwithstanding s. 600.03 (37m), "preferred provider plan" means
4 a health benefit plan offered by an organization established under ch. 185, 611, 613,
5 or 614 or issued a certificate of authority under ch. 618 that makes available to its
6 enrollees, without referral and for consideration other than predetermined periodic
7 fixed payments, coverage of either comprehensive health care services or a limited
8 range of health care services, regardless of whether the health care services are
9 performed by participating or nonparticipating providers.

10 **SECTION 9.** 609.20 (3) of the statutes is created to read:

11 609.20 **(3)** (a) Except as provided otherwise in this chapter, the commissioner
12 may not promulgate a rule or impose any requirement that regulates a contract
13 between a preferred provider plan and its participating providers.

14 (b) The commissioner may not promulgate a rule that establishes limits on, or
15 that requires certain amounts or levels for, copayments, deductibles, or penalties
16 imposed by preferred provider plans.

17 **SECTION 10.** 609.20 (4) of the statutes is created to read:

18 609.20 **(4)** The commissioner may not promulgate a rule that requires a defined
19 network plan to provide notice about nonparticipating provider limitations in
20 addition to the notice required under s. 609.23 (1).

21 **SECTION 11.** 609.22 (1m) of the statutes is created to read:

22 609.22 **(1m)** ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. (a) To satisfy
23 the requirements in sub. (1), a preferred provider plan shall ensure that, for the
24 provision of obstetric and gynecologic services, each female enrollee has access to at
25 least one primary care provider who provides those services.

1 (b) Except as provided in this section and in s. 609.20, the commissioner may
2 not promulgate a rule that imposes any additional requirements for preferred
3 provider plans relative to access to obstetric and gynecologic services.

4 **SECTION 12.** 609.22 (9) of the statutes is created to read:

5 609.22 **(9)** PROHIBITION ON USE OF UTILIZATION MANAGEMENT. An insurer offering
6 a preferred provider plan may not use utilization management techniques, including
7 prior authorization requirements or similar methods, to deny access to
8 nonparticipating providers.

9 **SECTION 13.** 609.23 of the statutes is created to read:

10 **609.23 Required notices. (1)** DEFINED NETWORK PLANS. A defined network
11 plan shall include in its marketing materials, in substantially similar language, the
12 following notice:

****NOTE: I left "conspicuously placed" out of this language, too. OK?

13 **IMPORTANT NOTICE**
14 **YOUR BENEFITS MAY BE REDUCED WHEN**
15 **NONPARTICIPATING PROVIDERS ARE USED**

16 **Please be aware that your benefits when you use participating**
17 **providers may be different from the benefits when you use**
18 **nonparticipating providers. Your plan may actually reduce your benefits**
19 **when you use nonparticipating providers. To find out about your benefits,**
20 **please read the benefit information found in these materials and in your**
21 **plan documents, or you may call [insert phone number of insurer].**

****NOTE: I did not include a reference to the guide prepared by OCI because, unless one has been prepared already, the effective date for this notice would have to be delayed. A reference to the guide, when it is prepared, may be included by insurers in this notice, however, because of the "substantially similar" language.

1 **(2)** PREFERRED PROVIDER PLANS. A preferred provider plan shall include in its
2 provider directory, in substantially similar language, the following notice:

3 **IMPORTANT NOTICE**

4 **You are strongly encouraged to contact us to verify the status of the**
5 **providers involved in your care including, for example, the**
6 **anesthesiologist, radiologist, pathologist, facility, clinic, or laboratory,**
7 **when scheduling appointments or elective procedures to determine**
8 **whether each provider is a participating or nonparticipating provider.**
9 **Such information may assist you in your selection of providers and will**
10 **likely affect the level of copayment, deductible, and coinsurance applicable**
11 **to the care you receive. The information contained in this directory may**
12 **change during your plan year. Please contact [insert phone number of**
13 **insurer] to learn more about the participating providers in your network**
14 **and the implications, including financial, if you decide to receive your care**
15 **from nonparticipating providers.**

16 **SECTION 14.** 609.35 of the statutes is renumbered 609.35 (2).

17 **SECTION 15.** 609.35 (1) of the statutes is created to read:

18 609.35 **(1)** In this section, a preferred provider plan covers the same service
19 when performed by a nonparticipating provider that it covers when performed by a
20 participating provider, if any of the following applies:

21 (a) The coinsurance differential between a participating and a
22 nonparticipating provider paid by an insured for the service is 40 percent or less.

23 (b) Coinsurance paid by an insured for the service when performed by a
24 nonparticipating provider is 50 percent or less.

25 **SECTION 16.** 609.82 of the statutes is renumbered 609.82 (1).

1 **SECTION 17.** 609.82 (2) of the statutes is created to read:

2 609.82 **(2)** (a) Except as provided in pars. (b) and (c), if a preferred provider plan
3 provides coverage of emergency medical services, the preferred provider plan shall
4 cover emergency medical services provided to an enrollee during the treatment of an
5 emergency medical condition, as defined in s. 632.85 (1) (a), by a nonparticipating
6 provider as though the services were provided by a participating provider, if any of
7 the following applies:

8 1. The enrollee could not reasonably reach a participating provider for
9 treatment of the emergency medical condition.

10 2. As a result of the emergency, the enrollee was admitted to a nonparticipating
11 provider for inpatient care.

12 (b) The coverage under par. (a) may be subject to any restrictions that govern
13 payment to a participating provider for emergency medical services. The preferred
14 provider plan shall pay the nonparticipating provider at the rate at which it pays a
15 nonparticipating provider, after applying any copayments, deductibles, or other
16 cost–sharing requirements that apply to a participating provider.

17 (c) A preferred provider plan is required to provide the coverage under par. (a)
18 only with respect to services that are needed to stabilize, as defined in section 1867
19 of the federal Social Security Act, the enrollee's emergency medical condition.

20 **SECTION 18.** 611.67 (1) (d) of the statutes is repealed.

21 **SECTION 19.** 628.36 (2m) (a) 3. of the statutes is repealed.

22 **SECTION 20.** 632.745 (15) of the statutes is amended to read:

23 632.745 **(15)** "Insurer" means an insurer that is authorized to do business in
24 this state, in one or more lines of insurance that includes health insurance, and that
25 offers health benefit plans covering individuals in this state or eligible employees of

one or more employers in this state. The term includes a health maintenance organization, a preferred provider plan, ~~as defined in s. 609.01 (4),~~ an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

SECTION 21. 632.84 (3) of the statutes is amended to read:

632.84 **(3)** EXCEPTIONS. This section does not apply to a health maintenance organization, as defined in s. 609.01 (2), limited service health organization, as defined in s. 609.01 (3), or preferred provider plan~~, as defined in s. 609.01~~.

SECTION 22. 632.86 (1) (a) of the statutes is amended to read:

632.86 **(1)** (a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a), except that the term does not include coverage under a health maintenance organization, as defined in s. 609.01 (2), a limited service health organization, as defined in s. 609.01 (3), a preferred provider plan, ~~as defined in s. 609.01 (4),~~ or a sickness care plan operated by a cooperative association organized under ss. 185.981 to 185.985.

SECTION 23. 632.895 (14) (d) 3. of the statutes is amended to read:

632.895 **(14)** (d) 3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan~~, as defined in s. 609.01 (4),~~ that is not a defined network plan, as defined in s. 609.01 (1b).

SECTION 24. 635.02 (8) of the statutes is amended to read:

635.02 **(8)** "Small employer insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employees of one or more small employers in this state, or that sells 3 or more individual health benefit plans to a small employer, covering eligible employees of the small employer.

The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, ~~as defined in s. 609.01 (4),~~ and an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, but does not include a limited service health organization, as defined in s. 609.01 (3).

SECTION 25. Initial applicability.

(1) COVERAGE OF SAME SERVICES AND EMERGENCY MEDICAL SERVICES. The renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes first apply to all of the following:

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

(b) Policies, plans, or contracts covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with the renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes that are issued or renewed on the earlier of the following:

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

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

(2) ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. If an insurance policy, plan, or certificate that is issued by a preferred provider plan and that is in effect on the effective date of this subsection, or a contract that is in effect on the effective date of this subsection between a provider and a preferred provider plan, contains a provision that is inconsistent with the treatment of section 609.22 (1m) (a) of the statutes, the treatment of section 609.22 (1m) (a) of the statutes first applies to that policy, plan, certificate, or contract on the date on which it is renewed.

1 (3) PRIOR AUTHORIZATION REQUIREMENTS. If an insurance policy, plan, or
2 certificate that is issued by a preferred provider plan and that is in effect on the
3 effective date of this subsection, or a contract that is in effect on the effective date of
4 this subsection between a provider and a preferred provider plan, contains a
5 provision that is inconsistent with the treatment of section 609.22 (9) of the statutes,
6 the treatment of section 609.22 (9) of the statutes first applies to that policy, plan,
7 certificate, or contract on the date on which it is renewed.

8 **(END)**

LRB-4636/P1
CMH:jld

This draft replaces LRB-4455. Due to a computer error, we had to assign a new LRB number.

CMH

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–4636/P1dn
CMH&PJK:jld:jf

February 13, 2006

This draft replaces LRB–4455. Due to a computer error, we had to assign a new LRB number.

Cathlene Hanaman
Legislative Attorney
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State of Wisconsin
2005 – 2006 LEGISLATURE

4636/1

LRB–4275/1
CMH&PJK:jld&kjf:jf

Stays

LPS - please note underlying doc. # (don't use LRB-4636/P1

Tues AM

2005 BILL

Companion bill no changes

Regen cat

AN ACT ***to repeal*** 611.67 (1) (d) and 628.36 (2m) (a) 3.; ***to renumber*** 609.35 and 609.82; ***to renumber and amend*** 609.01 (4); ***to amend*** 51.20 (7) (am), 149.10 (8m), 150.84 (5), 600.03 (23g) (a), 601.47 (3), 632.745 (15), 632.84 (3), 632.86 (1) (a), 632.895 (14) (d) 3. and 635.02 (8); and ***to create*** 601.47 (2m), 609.01 (4g), 609.20 (3), 609.20 (4), 609.22 (1m), 609.22 (9), 609.23, 609.35 (1) and 609.82 (2) of the statutes; **relating to:** prohibiting certain rules related to defined network plans and preferred provider plans, requiring defined network plans and preferred provider plans to provide certain notices, requiring the commissioner of insurance to publish a guide describing out–of–network coverage for all defined network plans, and other miscellaneous provisions related to preferred provider plans.

Analysis by the Legislative Reference Bureau

Current law contains various provisions that apply specifically to defined network plans and preferred provider plans. A defined network plan is a hospital or medical policy or certificate that requires, or provides incentives for, enrollees to obtain health care services from providers that are managed, owned, under contract

with, or employed by the insurer offering the policy or certificate (participating providers). Specifically excluded, however, are limited–scope dental or vision plans. A health maintenance organization is an example of a defined network plan. A preferred provider plan, which covers either comprehensive or limited health care services provided by either participating or nonparticipating providers, is also a defined network plan, except for one that is a limited–scope dental or vision plan, because obtaining services from participating providers usually requires lower levels of cost–sharing than obtaining services from nonparticipating providers. This bill makes various changes relating to defined network plans and preferred provider plans, including the following:

1. Changes the definition of a preferred provider plan so that the requirements pertaining to preferred provider plans do not apply to preferred provider plans that are limited–scope dental or vision plans.

2. Prohibits the commissioner of insurance (commissioner) from promulgating a rule that regulates contracts between a preferred provider plan and its participating providers or that establishes limits or levels for copayments, deductibles, or penalties imposed by preferred provider plans.

3. Clarifies that a preferred provider plan covers the same service when it is performed by a nonparticipating provider that the plan covers when the service is performed by a participating provider if either the coinsurance differential paid by an enrollee is 40 percent or less or the coinsurance paid by an enrollee is 50 percent or less.

4. Establishes that preferred provider plans have complied with certain access requirements if the number of primary care providers available is consistent with normal practices and standards in the geographic area and if each female enrollee has access to at least one primary care provider who provides obstetric and gynecologic services and prohibits additional requirements by rule.

5. Requires a defined network plan to include a notice in its marketing materials to alert a prospective enrollee that benefits may be reduced when services are obtained from a nonparticipating provider and prohibits the commissioner from promulgating rules that require additional notice about nonparticipating provider limitations.

6. Requires a preferred provider plan to include in its provider directory a notice that encourages an enrollee to contact the preferred provider plan to verify whether a provider involved in his or her care is a participating or nonparticipating provider, since that may affect the enrollee's level of cost–sharing.

7. Requires the commissioner to publish and distribute a guide that describes out–of–network coverage for all defined network plans.

8. Prohibits a preferred provider plan from using utilization management techniques, including prior authorization requirements, to deny access to nonparticipating providers.

9. Generally, requires a preferred provider plan that covers emergency services to cover treatment of an emergency medical condition by a nonparticipating provider as though the services were provided by a participating provider if: a) the enrollee could not reasonably reach a participating provider for the treatment; or b) as a

result of the emergency, the enrollee was admitted to a nonparticipating provider for inpatient care.

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

1 **SECTION 1.** 51.20 (7) (am) of the statutes is amended to read:

2 51.20 **(7)** (am) A subject individual may not be examined, evaluated or treated
3 for a nervous or mental disorder pursuant to a court order under this subsection
4 unless the court first attempts to determine whether the person is an enrollee of a
5 health maintenance organization, as defined in s. 609.01 (2), limited service health
6 organization, as defined in s. 609.01 (3), or preferred provider plan, as defined in s.
7 ~~609.01~~ 600.03 (37m), and, if so, notifies the organization or plan that the subject
8 individual is in need of examination, evaluation or treatment for a nervous or mental
9 disorder.

10 **SECTION 2.** 149.10 (8m) of the statutes is amended to read:

11 149.10 **(8m)** "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~
12 600.03 (37m).

13 **SECTION 3.** 150.84 (5) of the statutes is amended to read:

14 150.84 **(5)** "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~
15 600.03 (37m).

16 **SECTION 4.** 600.03 (23g) (a) of the statutes is amended to read:

17 600.03 **(23g)** (a) Contracts with a health maintenance organization, as defined
18 in s. 609.01 (2), limited service health organization, as defined in s. 609.01 (3), or
19 preferred provider plan~~, as defined in s. 609.01,~~ to provide health care services.

20 **SECTION 5.** 601.47 (2m) of the statutes is created to read:

601.47 **(2m)** The commissioner shall prepare and publish a guide that describes out–of–network coverage for all defined network plans and distribute it in a manner that the commissioner determines. The cost of publication and distribution may be paid from the appropriation under s. 20.145 (1) (g).

SECTION 6. 601.47 (3) of the statutes is amended to read:

601.47 **(3)** FREE DISTRIBUTION. The commissioner may furnish free copies of the publications prepared under subs. (1) ~~and~~, (2), and (2m) to public officers and libraries in this state and elsewhere. The cost of free distribution shall be charged to the appropriation under s. 20.145 (1) (g).

SECTION 7. 609.01 (4) of the statutes is renumbered 600.03 (37m) and amended to read:

600.03 **(37m)** "Preferred provider plan" means a health care plan, as defined in s. 628.36 (2) (a) 1., that is offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 and that makes available to its enrollees, without referral and for consideration other than predetermined periodic fixed payments, coverage of either comprehensive health care services or a limited range of health care services, regardless of whether the health care services are performed by participating, as defined in s. 609.01 (3m), or nonparticipating providers, as defined in s. 609.01 (5m).

SECTION 8. 609.01 (4g) of the statutes is created to read:

609.01 **(4g)** Notwithstanding s. 600.03 (37m), "preferred provider plan" means a health benefit 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, without referral and for consideration other than predetermined periodic fixed payments, coverage of either comprehensive health care services or a limited

1 range of health care services, regardless of whether the health care services are
2 performed by participating or nonparticipating providers.

3 **SECTION 9.** 609.20 (3) of the statutes is created to read:

4 609.20 **(3)** (a) Except as provided otherwise in this chapter, the commissioner
5 may not promulgate a rule or impose any requirement that regulates a contract
6 between a preferred provider plan and its participating providers.

7 (b) The commissioner may not promulgate a rule that establishes limits on, or
8 that requires certain amounts or levels for, copayments, deductibles, or penalties
9 imposed by preferred provider plans.

10 **SECTION 10.** 609.20 (4) of the statutes is created to read:

11 609.20 **(4)** The commissioner may not promulgate a rule that requires a defined
12 network plan to provide notice about nonparticipating provider limitations in
13 addition to the notice required under s. 609.23 (1).

14 **SECTION 11.** 609.22 (1m) of the statutes is created to read:

15 609.22 **(1m)** ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. (a) A preferred
16 provider plan meets all of the requirements in sub. (1) if the preferred provider plan
17 does all of the following:

18 1. Ensures that each enrollee has access, consistent with normal practices and
19 standards in the geographic area, to at least one primary care provider.

20 2. Ensures that, for the provision of obstetric and gynecologic services, each
21 female enrollee has access, consistent with normal practices and standards in the
22 geographic area, to at least one primary care provider who provides those services.

23 (b) Except as provided in this section and in s. 609.20, the commissioner may
24 not promulgate a rule that imposes any additional requirements for preferred

provider plans relative to access to primary care providers or obstetric and gynecologic services.

SECTION 12. 609.22 (9) of the statutes is created to read:

609.22 **(9)** PROHIBITION ON USE OF UTILIZATION MANAGEMENT. An insurer offering a preferred provider plan may not use utilization management techniques, including prior authorization requirements or similar methods, to deny access to nonparticipating providers.

SECTION 13. 609.23 of the statutes is created to read:

609.23 Required notices. (1) DEFINED NETWORK PLANS. A defined network plan shall include in its marketing materials, in substantially similar language, the following notice:

IMPORTANT NOTICE

YOUR BENEFITS MAY BE REDUCED WHEN

NONPARTICIPATING PROVIDERS ARE USED

Please be aware that your benefits when you use participating providers may be different from the benefits when you use nonparticipating providers. Your plan may actually reduce your benefits when you use nonparticipating providers. To find out about your benefits, please read the benefit information found in these materials and in your plan documents, or you may call [insert phone number of insurer].

(2) PREFERRED PROVIDER PLANS. A preferred provider plan shall include in its provider directory, in substantially similar language, the following notice:

IMPORTANT NOTICE

You are strongly encouraged to contact us to verify the status of the providers involved in your care including, for example, the

1 **anesthesiologist, radiologist, pathologist, facility, clinic, or laboratory,**
2 **when scheduling appointments or elective procedures to determine**
3 **whether each provider is a participating or nonparticipating provider.**
4 **Such information may assist you in your selection of providers and will**
5 **likely affect the level of copayment, deductible, and coinsurance applicable**
6 **to the care you receive. The information contained in this directory may**
7 **change during your plan year. Please contact [insert phone number of**
8 **insurer] to learn more about the participating providers in your network**
9 **and the implications, including financial, if you decide to receive your care**
10 **from nonparticipating providers.**

11 **SECTION 14.** 609.35 of the statutes is renumbered 609.35 (2).

12 **SECTION 15.** 609.35 (1) of the statutes is created to read:

13 609.35 **(1)** In this section, a preferred provider plan covers the same service
14 when performed by a nonparticipating provider that it covers when performed by a
15 participating provider, if any of the following applies:

16 (a) The coinsurance differential between a participating and a
17 nonparticipating provider paid by an enrollee for the service is 40 percent or less.

18 (b) Coinsurance paid by an enrollee for the service when performed by a
19 nonparticipating provider is 50 percent or less.

20 **SECTION 16.** 609.82 of the statutes is renumbered 609.82 (1).

21 **SECTION 17.** 609.82 (2) of the statutes is created to read:

22 609.82 **(2)** (a) Except as provided in pars. (b) and (c), if a preferred provider plan
23 provides coverage of emergency medical services, the preferred provider plan shall
24 cover emergency medical services provided to an enrollee during the treatment of an
25 emergency medical condition, as defined in s. 632.85 (1) (a), by a nonparticipating

1 provider as though the services were provided by a participating provider, if any of
2 the following applies:

3 1. The enrollee could not reasonably reach a participating provider for
4 treatment of the emergency medical condition.

5 2. As a result of the emergency, the enrollee was admitted to a nonparticipating
6 provider for inpatient care.

7 (b) The coverage under par. (a) may be subject to any restrictions that govern
8 payment to a participating provider for emergency medical services. The preferred
9 provider plan shall pay the nonparticipating provider at the rate at which it pays a
10 nonparticipating provider, after applying any copayments, deductibles, or other
11 cost–sharing requirements that apply to a participating provider.

12 (c) A preferred provider plan is required to provide the coverage under par. (a)
13 only with respect to services that are needed to stabilize, as defined in section 1867
14 of the federal Social Security Act, the enrollee's emergency medical condition.

15 **SECTION 18.** 611.67 (1) (d) of the statutes is repealed.

16 **SECTION 19.** 628.36 (2m) (a) 3. of the statutes is repealed.

17 **SECTION 20.** 632.745 (15) of the statutes is amended to read:

18 632.745 **(15)** "Insurer" means an insurer that is authorized to do business in
19 this state, in one or more lines of insurance that includes health insurance, and that
20 offers health benefit plans covering individuals in this state or eligible employees of
21 one or more employers in this state. The term includes a health maintenance
22 organization, a preferred provider plan, ~~as defined in s. 609.01 (4),~~ an insurer
23 operating as a cooperative association organized under ss. 185.981 to 185.985 and
24 a limited service health organization, as defined in s. 609.01 (3).

25 **SECTION 21.** 632.84 (3) of the statutes is amended to read:

632.84 **(3)** EXCEPTIONS. This section does not apply to a health maintenance organization, as defined in s. 609.01 (2), limited service health organization, as defined in s. 609.01 (3), or preferred provider plan~~, as defined in s. 609.01~~.

SECTION 22. 632.86 (1) (a) of the statutes is amended to read:

632.86 **(1)** (a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a), except that the term does not include coverage under a health maintenance organization, as defined in s. 609.01 (2), a limited service health organization, as defined in s. 609.01 (3), a preferred provider plan, ~~as defined in s. 609.01 (4),~~ or a sickness care plan operated by a cooperative association organized under ss. 185.981 to 185.985.

SECTION 23. 632.895 (14) (d) 3. of the statutes is amended to read:

632.895 **(14)** (d) 3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan~~, as defined in s. 609.01 (4),~~ that is not a defined network plan, as defined in s. 609.01 (1b).

SECTION 24. 635.02 (8) of the statutes is amended to read:

635.02 **(8)** "Small employer insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employees of one or more small employers in this state, or that sells 3 or more individual health benefit plans to a small employer, covering eligible employees of the small employer. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, ~~as defined in s. 609.01 (4),~~ and an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, but does not include a limited service health organization, as defined in s. 609.01 (3).

SECTION 25. Initial applicability.

1 (1) COVERAGE OF SAME SERVICES AND EMERGENCY MEDICAL SERVICES. The
2 renumbering of sections 609.35 and 609.82 of the statutes and the creation of
3 sections 609.35 (1) and 609.82 (2) of the statutes first apply to all of the following:
4 (a) Except as provided in paragraph (b), policies, plans, or contracts that are
5 issued or renewed on the effective date of this paragraph.
6 (b) Policies, plans, or contracts covering employees who are affected by a
7 collective bargaining agreement containing provisions inconsistent with the
8 renumbering of sections 609.35 and 609.82 of the statutes and the creation of
9 sections 609.35 (1) and 609.82 (2) of the statutes that are issued or renewed on the
10 earlier of the following:
11 1. The day on which the collective bargaining agreement expires.
12 2. The day on which the collective bargaining agreement is extended, modified,
13 or renewed.
14 (2) ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. If an insurance policy,
15 plan, or certificate that is issued by a preferred provider plan and that is in effect on
16 the effective date of this subsection, or a contract that is in effect on the effective date
17 of this subsection between a provider and a preferred provider plan, contains a
18 provision that is inconsistent with the treatment of section 609.22 (1m) (a) of the
19 statutes, the treatment of section 609.22 (1m) (a) of the statutes first applies to that
20 policy, plan, certificate, or contract on the date on which it is renewed.
21 (3) PRIOR AUTHORIZATION REQUIREMENTS. If an insurance policy, plan, or
22 certificate that is issued by a preferred provider plan and that is in effect on the
23 effective date of this subsection, or a contract that is in effect on the effective date of
24 this subsection between a provider and a preferred provider plan, contains a
25 provision that is inconsistent with the treatment of section 609.22 (9) of the statutes,

1 the treatment of section 609.22 (9) of the statutes first applies to that policy, plan,
2 certificate, or contract on the date on which it is renewed.
3 **(END)**

Northrop, Lori

From: Perlich, John H.
Sent: Monday, February 20, 2006 2:36 PM
To: LRB.Legal
Subject: Draft Review: LRB 05-4636/1 Topic: Defined network plans

Please put a rush on this jacket so it can get put on to a Joint Hearing agenda for Wed. morning. I need it ASAP. Thank you.

Please Jacket LRB 05-4636/1 for the SENATE.

John H. Perlich
Office of Senator Kapanke

This is the Senate Companion to AB 1052 (LRB-4275)