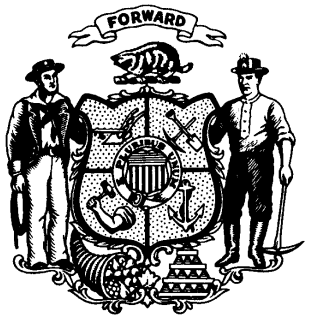
State of Wisconsin



2005 Senate Bill 617

Date of enactment:
Date of publication*:

2005 WISCONSIN ACT

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), 609.20 (title), 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 point−of−service 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.

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

* Section 991.11, WISCONSIN STATUTES 2003−04 : Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

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

SECTION 8m. 609.20 (title) of the statutes is amended to read:

609.20 (title) **Rules for preferred provider ~~and,~~ defined network, and point−of−service plans.**

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

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

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

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

609.20 **(4)** The commissioner may not promulgate a rule that requires a preferred provider plan or a point−of−service plan to provide notice about nonparticipating provider limitations in addition to the notice required under s. 609.23 (1).

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

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

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

2. Ensures that, for the provision of obstetric and gynecologic services, each female enrollee has access, consistent with normal practices and standards in the geographic area, to at least one physician who specializes in obstetrics and gynecology.

(b) Except as provided in this section and in s. 609.20, the commissioner may 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) PREFERRED PROVIDER AND POINT−OF−SERVICE PLANS. (a) A preferred provider plan and a point−of−service plan shall include in their marketing materials information that is understandable to a layperson that describes the differences in benefits when using participating and nonparticipating providers.

(b) The requirement under par. (a) may be satisfied by including in marketing materials 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 anesthesiologist, radiologist, pathologist, facility, clinic, or laboratory, when scheduling appointments or elective procedures to determine whether each provider is a participating or nonparticipating provider. Such information may assist you in your selection of providers and will likely affect the level of copayment, deductible, and coinsurance applicable to the care you receive. The information contained in this directory may change during

your plan year. Please contact [insert phone number of insurer] to learn more about the participating providers in your network and the implications, including financial, if you decide to receive your care from nonparticipating providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

632.745 **(15)** "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 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.

(3) PRIOR AUTHORIZATION REQUIREMENTS. 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 (9) of the statutes, the treatment of section 609.22 (9) of the statutes first applies to that policy, plan, certificate, or contract on the date on which it is renewed.