CHAPTER 609

HEALTH MAINTENANCE ORGANIZATIONS, LIMITED SERVICE HEALTH ORGANIZATIONS AND PREFERRED PROVIDER PLANS

NOTE: See note following s. 609.60 prepared by the commissioner of insurance concerning provisions of chs. 600 to 655 that apply to organizations under ch. 609.

609.001 Joint ventures; legislative findings. (1) The legislature finds that increased development of health maintenance organizations, preferred provider plans and limited service health organizations may have the effect of putting small, independent health care providers at a competitive disadvantage with larger health care providers. In order to avoid monopolistic situations and to provide competitive alternatives, it may be necessary for those small, independent health care providers to form joint ventures. The legislature finds that these joint ventures are a desirable means of health care cost containment to the extent that they increase the number of entities with which a health maintenance organization, preferred provider plan or limited service health organization may choose to contract and to the extent that the joint ventures do not violate state or federal antitrust laws.

(2) The legislature finds that competition in the health care market will be enhanced by allowing employers and organizations which otherwise act independently to join together in a manner consistent with the state and federal antitrust laws for the purpose of purchasing health care coverage for employes and members. These joint ventures will allow purchasers of health care coverage to obtain volume discounts when they negotiate with insurers and health care providers. These joint ventures should result in an improved business climate in this state because of reduced costs for health care coverage.

History: 1985 a. 29.

609.01 Definitions. In this chapter:

(1) "Health care plan" has the meaning given under s. 628.36 (2) (a) 1.

(2) "Health maintenance organization" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

(3) "Limited service health organization" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined periodic fixed payments, a limited range of health care services performed by providers selected by the organization.

(4) "Preferred provider plan" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, for consideration other than predetermined periodic fixed payments, either comprehensive health care services or a limited range of health care services performed by providers selected by the organization.

(5) "Primary provider" means a selected provider who is an individual and who is designated by an enrolled participant.

(6) "Selected provider" means a provider, as defined in s. 628.36 (2) (a) 2, selected by a health maintenance organization, limited service health organization or preferred provider plan to perform health care services for enrolled participants.

(7) "Standard plan" means a health care plan other than a health maintenance organization or a preferred provider plan.

History: 1985 a. 29.

609.05 Primary provider and referrals. (1) Except as provided in subs. (2) and (3), a health maintenance organization, limited service health organization or preferred provider plan shall permit its enrolled participants to choose freely among selected providers.

(2) A health care plan under sub. (1) may require an enrolled participant to designate a primary provider and to obtain health care services from the primary provider when reasonably possible.

(3) A health care plan under sub. (1) may require an enrolled participant to obtain a referral from the primary provider designated under sub. (2) to another selected provider prior to obtaining health care services from the other selected provider.

History: 1985 a. 29.

609.10 Standard plan required. (1) (a) Except as provided in subs. (2) to (4), an employer that offers any of its employes a health maintenance organization or a preferred provider plan that provides comprehensive health care services shall also offer the employes a standard plan, as provided in pars. (b) and (c), that provides at least substantially equivalent coverage of health care expenses and that is not a health maintenance organization or a preferred provider plan.

(b) At least once annually, the employer shall provide the employes the opportunity to enroll in the health care plans under par. (a).

(c) The employer shall provide the employes adequate notice of the opportunity to enroll in the health care plans under par. (a) and shall provide the employes complete and understandable information concerning the differences between the health maintenance organization or preferred provider plan and the standard plan.

(2) If, after providing an opportunity to enroll under sub. (1) (b) and the notice and information under sub. (1) (c), fewer than 25 employes indicate that they wish to enroll in the standard plan under sub. (1) (a), the employer need not offer the standard plan on that occasion.

(3) Subsection (1) does not apply to an employer that employs fewer than 25 full-time employes.

(4) Nothing in sub. (1) requires an employer to offer a particular health care plan to an employe if the health care plan determines that the employe does not meet reasonable medical underwriting standards of the health care plan.

(5) The commissioner may establish by rule standards in addition to those established under s. 609.20 for what constitutes adequate notice and complete and understandable information under sub. (1) (c).

History: 1985 a. 29.

609.15 Grievance procedure. (1) Each health maintenance organization, limited service health organization and preferred provider plan shall do all of the following:

(a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. (2) for the resolution of enrolled participants' grievances with the health care plan.

(b) Provide enrolled participants with complete and understandable information describing the internal grievance procedure under par. (a).

(c) Submit an annual report to the commissioner describing the internal grievance procedure under par. (a) and summarizing the experience under the procedure for the year.

(2) The internal grievance procedure established under sub. (1) (a) shall include all of the following elements:

(a) The opportunity for an enrolled participant to submit a written grievance in any form.

(b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one enrolled participant other than the grievant, if an enrolled participant is available to serve on the grievance panel.

(c) Prompt investigation of each grievance submitted under par. (a).

(d) Notification to each grievant of the disposition of his or her grievance and of any corrective action taken on the grievance.

(e) Retention of records pertaining to each grievance for at least 3 years after the date of notification under par. (d).

History: 1985 a. 29.

609.17 Reports of disciplinary action. Every health maintenance organization, limited service health organization and preferred provider plan shall notify the medical examining board of any disciplinary action taken against a selected provider who holds a license or certificate granted by the board.

History: 1985 a. 340.

609.20 Rules for preferred provider plans. The commissioner shall promulgate rules applicable to preferred provider plans for all of the following purposes:

(1) To ensure that enrolled participants are not forced to travel excessive distances to receive health care services.

(2) To ensure that the continuity of patient care for enrolled participants is not disrupted.

(3) To define substantially equivalent coverage of health care expenses for purposes of s. 609.10 (1) (a).

(4) To ensure that employes offered a preferred provider plan that provides comprehensive services under s. 609.10 (1) (a) are given adequate notice of the opportunity to enroll and complete and understandable information under s. 609.10 (1) (c) concerning the differences between the preferred provider plan and the standard plan, including differences between providers available and differences resulting from special limitations or requirements imposed by an institutional provider because of its affiliation with a religious organization.

History: 1985 a. 29.

609.60 Optometric coverage. Health maintenance organizations and preferred provider plans are subject to s. 632.87 (2m).

History: 1985 a. 29.

NOTE: The following note is prepared by the commissioner of insurance as provided in s. 601.21.

Statutes not contained in this chapter that relate to or impose restrictions include, but are not limited to, the following:

I. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, LIMITED SERVICE HEALTH ORGANIZATIONS AND PREFERRED PROVIDER PLANS ORGANIZED UNDER CH. 185.

Insurance - administration:	
Certificate of authority; fee	**601.04**
Fees	**601.31**
Examinations and alternatives	**601.43**
Conducting examinations	**601.44**
Examination costs	**601.45**
Domestic stock and mutual insurance corporations:	
Management contract services	**611.67**
Risk sharing plans:	
Mandatory health care liability risk sharing plans	**619.04**
Mandatory health insurance risk sharing plan	**Subch. II of Ch. 619**
General public policy provisions applicable to insurers and others	**Ch. 630**
Insurance contracts in specific lines:	
Notice of termination of group hospital, surgical or medical expense insurance coverage due to cessation of business or default in payment of premiums	**632.79**
Restrictions on health care services - vision care	**632.87 (2m)**
Coverage of newborn infants	**632.895 (5)**
Insurers rehabilitation and liquidation	**Ch. 645**

II. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, PREFERRED PROVIDER PLANS OR LIMITED SERVICE HEALTH ORGANIZATIONS LICENSED UNDER CHAPTER 611:

Domestic stock and mutual insurance corporations	**Ch. 611**
Insurance - investments:	
Segregated account investments	**620.02**
Insurance - accounting and reserves:	
Accounting for repurchased shares	**623.34**
Insurance security fund	**Ch. 646**

III. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, PREFERRED PROVIDER PLANS OR LIMITED SERVICE HEALTH ORGANIZATIONS LICENSED UNDER CHAPTER 613:

Service insurance corporations	**Ch. 613**

IV. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, LIMITED SERVICE HEALTH ORGANIZATIONS AND PREFERRED PROVIDER ORGANIZATIONS LICENSED UNDER CHAPTER 614:

Insurance - fraternals	**Ch. 614**
Insurance - accounting and reserves:	
Fraternal rates and reserves	**623.15**
Insurance marketing:	
Licensing of fraternal agents	**628.06**
Insurance contracts in specific lines:	
Fraternal insurance	**Subch. VII of Ch. 632**

V. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, LIMITED SERVICE HEALTH ORGANIZATIONS AND PREFERRED PROVIDER ORGANIZATIONS ISSUED A CERTIFICATE OF AUTHORITY UNDER CHAPTER 618:

Insurance - administration:	
Certificate of authority, fee	**601.04**
Enforcement of policyholder rights	**601.71**
Nondomestic insurers	**Ch. 618**

Insurance security fund Ch. 646
(Ch. 646 only applies to limited service health organizations.)

VI. LAWS THAT APPLY TO HEALTH MAINTENANCE ORGANIZATIONS, PREFERRED PROVIDER PLANS OR LIMITED SERVICE HEALTH ORGANIZATIONS ISSUED A CERTIFICATE OF AUTHORITY UNDER CH. 611, 613, 614 or 618:

Insurance - general provisions Ch. 600
Insurance-administration:
- Purposes 601.01
- Definitions 601.02
- Fees 601.31
- Supervision of industry, supplementary fee 601.32
- Reports and replies 601.42
- Examinations and alternatives 601.43
- Conducting examinations 601.44
- Examination costs 601.45

Subchapter V of Ch. 601 - procedures and enforcement 601.61 - 601.73
Insurers in general Ch. 610, except 610.61
Regulation of insurance holding companies and intercorporate transactions relating to insurers Ch. 617
Risk sharing plans:
- Mandatory health insurance risk sharing plan Subch. II of Ch. 619

Insurance - investments Ch. 620, except 620.02
Insurance - accounting and reserves:
- Applicability 623.01
- Standards for accounting rules 623.02
- Valuation of assets 623.03
- Valuation of liabilities 623.04
- Amount of compulsory surplus 623.11
- Amount of security surplus 623.12
- Adjustment of reserves 623.21

Rate regulation Ch. 625
Underwriting restrictions Ch. 627, except 627.15
Insurance marketing Ch. 628, except 628.05, 628.06 and 628.77
General public policy provisions applicable to insurers and others:
- Political contributions 630.05
- Lobbying 630.10

Insurance contracts generally Ch. 631, except 631.24, 631.37 and 631.69
- Assignment of life insurance rights 632.47
- Estoppel from medical examination 632.50
- Disability insurance Subch. VI of Ch. 632
- Certificate of disability 632.99

Insurers rehabilitation and liquidation Ch. 645