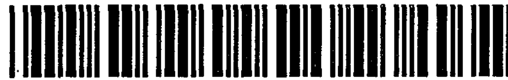
Patch II

99-2664df

sinicki

kahlepj



LRB-2664

1999 DRAFTING REQUEST

Bill

Received: **04/1/99**

Received By: **kahlepj**

Wanted: **As time permits**

Identical to LRB:

For: **Christine Sinicki (608) 266-8588**

By/Representing: **Jan**

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

Drafter: **kahlepj**

May Contact:

Alt. Drafters:

Subject: **Insurance - health**

Extra Copies:

Pre Topic:

No specific pre topic given

Topic:

Require health care plans to allow services by certain providers without referral

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kahlepj 04/5/99	jgeller 04/5/99					S&L
/1			ismith 04/8/99		lrb_docadmin 04/8/99		S&L
/2	kahlepj 04/9/99	jgeller 04/9/99	jfrantze 04/13/99		lrb_docadmin 04/13/99	lrb_docadmin 04/21/99	

FE Sent For: **04/21/99.** "/2"

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/2	kahlepj 04/9/99	jgeller 04/9/99	jfrantze 04/13/99	_______ _______	lrb_docadmin 04/13/99		

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/1		/2 4/9 jg	ismith 04/8/99		lrb_docadmin 04/8/99		

FE Sent For: 4/13 4/13

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By/Representing: **Jan**

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May Contact:

Alt. Drafters:

Subject: **Insurance - health**

Extra Copies:

Pre Topic:

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Topic:

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
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FE Sent For:

<END>

State of Wisconsin
1995 – 1996 LEGISLATURE

LRB–3329/1
PJK:skg:jlb

1995 AB 383?

AN ACT *to amend* 40.51 (9), 185.981 (7), 609.05 (2) and 609.05 (3); and *to create* 609.62 of the statutes; **relating to:** prohibiting referral requirement for obstetric or gynecological services.

Analysis by the Legislative Reference Bureau

Under current law, health maintenance organizations, limited service health organizations and preferred provider plans (health care plans) require enrolled participants to obtain health care services from health care providers that are selected by the health care plan (selected providers). A health care plan may require an enrolled participant to designate a primary provider from among its selected providers, obtain health care services from the primary provider whenever reasonably possible and obtain a referral from the primary provider to another selected provider before obtaining services from that other selected provider. This bill provides that a health care plan must allow a female enrolled participant to obtain obstetric or gynecological services from a selected provider who is a physician specializing in obstetrics and gynecology without having first obtained a referral to that selected provider, even if that selected provider is not the woman's primary provider. A health care plan must provide written notice of the requirement in its policies and group certificates and to each female enrolled participant and each female applicant for coverage at open enrollment time.

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

SECTION 1. 40.51 (9) of the statutes is amended to read:

40.51 **(9)** Every health maintenance organization and preferred provider plan offered by the state under sub. (6) shall comply with ~~s~~ ss. 609.62 and 632.87 (2m).

SECTION 2. 185.981 (7) of the statutes is amended to read:

185.981 **(7)** Notwithstanding sub. (4) and s. 185.982 (1), a sickness care plan that is operated by a cooperative association and that qualifies as a health maintenance organization, as defined in s. 609.01 (2), is subject to ~~s~~ ss. 609.62 and 609.655.

SECTION 3. 609.05 (2) of the statutes is amended to read:

609.05 **(2)** ~~A~~ Except as provided in s. 609.62, 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.

SECTION 4. 609.05 (3) of the statutes is amended to read:

609.05 **(3)** Except as provided in ss. 609.62, 609.65 and 609.655, 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.

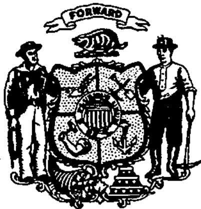
SECTION 5. 609.62 of the statutes is created to read:

609.62 Obstetric and gynecological services. (1) A health maintenance organization, limited service health organization or preferred provider plan shall allow a female enrolled participant to obtain obstetric or gynecological services from a selected provider who is a physician licensed under ch. 448 and who specializes in obstetrics and gynecology without first having obtained a referral to that selected provider, regardless of whether that selected provider is the enrolled participant's primary provider.

(2) A health care plan under sub. (1) shall provide written notice of the requirement under sub. (1) in each policy or group certificate issued by the health care plan

1 and, during each open enrollment period, to each female enrolled participant and
2 each female applicant for coverage.
3 (END)

Attn:
Jan



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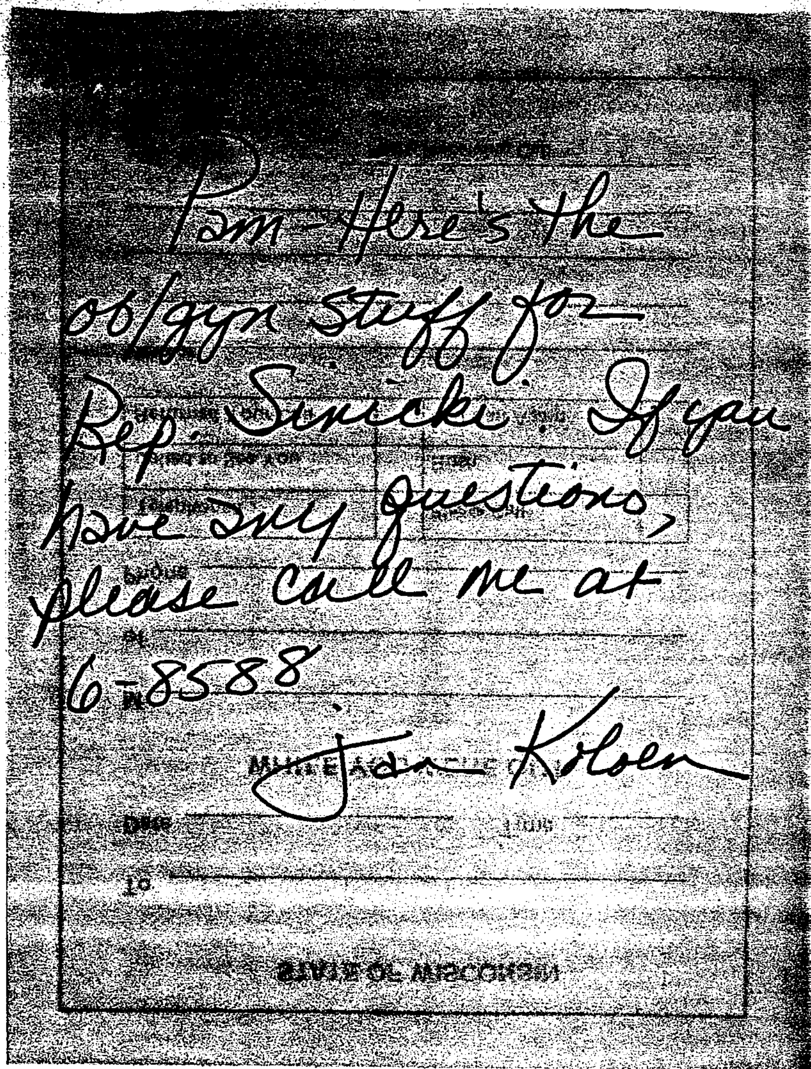

Pam- Here's the ob/gyn stuff for Rep. Sinicki. If you have any questions, please call me at 6-8588.

Jan Koloen

____ In response to your recent request.

____ I thought you might be interested in the enclosed material.

✓ Other Have fun!

PRINTED ON RECYCLED PAPER

Consumer Bill of Rights includes access to ob-gyns

A woman's right to seek health care from her ob-gyn without referral was included in the "Consumer Bill of Rights and Responsibilities" recommended by a presidential advisory commission in November. The bill of rights, the result of six months of intense debate, lays out broad health care system protections for consumers, although it does not specify how the rights would be guaranteed. President Clinton, however, quickly endorsed legislation to implement the rights.

The 34-member advisory commission of physicians, nurses, consumers, employers, and health plan representatives was appointed last year to address growing concerns about managed care policies.

ACOG played key role in ensuring ob-gyn access

Chief among the rights contained in the document is the right for women to choose an appropriate provider, including an ob-gyn, for their health care, without having to seek a referral. This right was approved by the full commission after ACOG and women's health care organizations launched a major campaign to educate the panel that access to ob-gyns is a key issue for women and has not been available in some managed care plans.

"As the largest group of health care consumers, women often are affected disproportionately by inappropriate changes in health care," ACOG Fellow Kathleen Fitzgerald, MD, of Rhode Island, testified before a commission subcommittee in September. "One of the most critical issues for women is access to ob-gyns for primary and specialty care, without referral," she told the commission.

Several commissioners expressed support for this right; others opposed designating ob-gyns as primary care physicians while supporting the direct access concept, but only for a limited number of visits. ACOG continually stressed the ob-gyn's primary care role and pushed for unlimited direct access. Ultimately, the commission compromised, stating that women have the right to choose an ob-gyn for "covered routine and preventive care," with no limit on the number of visits.

Highlights of the Consumer Bill of Rights

- **Access to qualified specialists for women's health care services**—Women have the right to choose an ob-gyn for covered routine and preventive health care services
- **Information**—Consumers should receive information about health plans, professionals, and facilities, including quality measurements
- **Access to specialists**—Consumers with complex medical conditions should have direct access to a qualified specialist of their choice within a plan's network
- **Transitional care**—If a health plan is changed or a provider is terminated for other than cause, consumers with a chronic condition or who are in the second or third trimester of pregnancy can continue to see their provider for 90 days or completion of postpartum care
- **Confidentiality of health information**—The confidentiality of an individual consumer's information should be protected
- **Right to complaints and appeals**—Consumers have the right to a fair and efficient process for resolving differences with their health plans and providers

Congress prepares for debate on consumer protections

Numerous bills have been introduced with strong bipartisan support to establish important consumer protections. For example, HR 1737 would allow women to choose their ob-gyn as their primary care provider and to have direct access to their ob-gyn for all ob-gyn services. ACOG is working to educate Congress that this bill, introduced by Reps. Nita Lowey (D-NY), Rick Lazio (R-NY), and Larry Combest (R-TX), is the best legislative vehicle to implement the commission's recommendation on women's access.

Strongly opposing such legislation, some health plans, insurers, and business groups, such as the Chamber of Commerce, prefer voluntary measures to protect consumers. However, equally strong support for legislation exists among organized medicine, other health care providers, and consumers. In addition, in a significant move, several large health plans have split from the managed care industry and have endorsed "legally enforceable" minimum standards, including women's access to ob-gyns.

"It's critical that Fellows let their senators and representatives know in the next several months how important it is to ensure that women have access to their ob-gyns."

Action by individual Fellows is critical

"Legislation guaranteeing a woman's right to access her ob-gyn will be passed only if we can sustain the support in Congress for minimum federal standards for health plans," predicts Carol Vargo, manager of Federal Government Relations at ACOG. "It's critical that Fellows let their senators and representatives know in the next several months how important it is to ensure that women have access to their ob-gyns."

For more information on the bill of rights or HR 1737 and how to contact your senators or representative, contact Ms. Vargo at 800-673-8444, ext 2510, or 202-863-2510; email cvargo@acog.org. ■

Media urged to join ACOG in reaching teens

Teenage girls are at risk for problems such as depression, infertility, cancer, and osteoporosis unless parents, health professionals, and the media help to change a culture that is harmful to young women. This was the message ACOG delivered at a December media briefing in New York City.

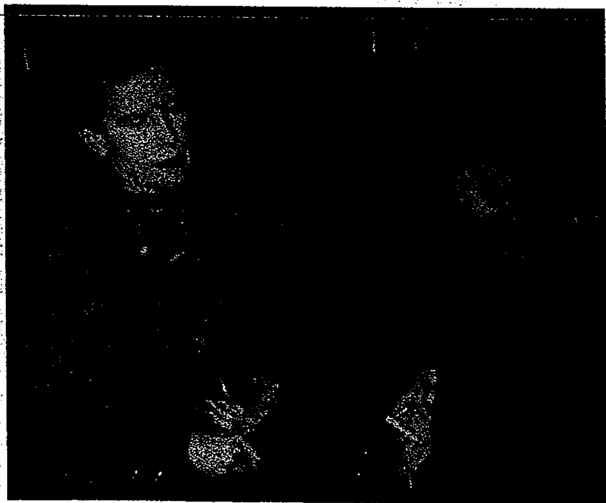
"Today's culture, coupled with a teenager's belief that 'it can't happen to me,' are putting girls at significant risk for poor health outcomes as adults," Luella Klein, MD, director of ACOG's Division of Women's Health Issues, told the media representatives. Among the contributing problems are earlier sexual activity, low self-esteem, cultural and peer pressures to smoke and drink, and violence and abuse, including date rape.

"We need to change the messages we're giving teens," said Ann J. Davis, MD, a Boston pediatric and adolescent gynecologist. "Society's emphasis on beauty leads to many unhealthy responses."

The "cult of thinness"

"Thin, pretty girls are virtually the only images of female teens shown in magazines, on television, and in the movies," Dr. Davis said, pointing out that 22% of high school girls reported in a recent survey that either they do not like or they hate themselves.

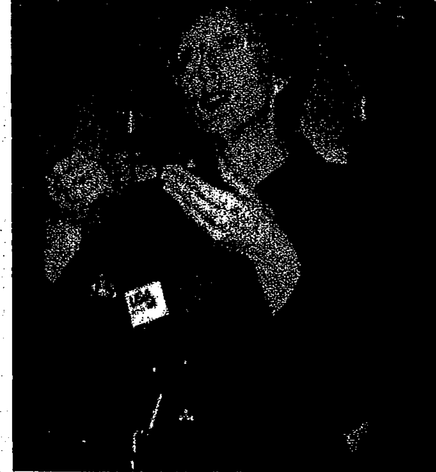
One of the serious problems sometimes directly associated with a desire to be thin is smoking, according to ACOG President Vicki L. Seltzer, MD, who reported that 34% of high school girls said they smoked cigarettes in the 30 days prior to a 1997 survey. "We must convince our daughters not to smoke," she urged.



Dr. Klein answers questions from a reporter.

Sexual activity starting earlier

By the 12th grade, 66% of teenage girls have had sex, reported Anita L. Nelson, MD, medical director of Women's Health Care Clinic, in Torrance, CA. "Teenagers need to be given accurate information about the risks associated with sex," Dr. Nelson said. She pointed out that journalists can play a key role in this, because teens rely on women's magazines for information. Women's magazines were well-represented in the audience, which included representatives from *Seventeen, Teen, YM, Essence, Mademoiselle, Glamour,* and *McCall's.*



Dr. Nelson addresses journalists at the December briefing.

Inappropriate role models a problem

Giving girls role models that will contribute to healthy lifestyles was a message stressed repeatedly at the media briefing. "Teens are very vulnerable to beginning risk-taking behavior, and much of what they see glamorizes sex, smoking, drinking, and even drug abuse," said Paula J. Hillard, MD, chair of ACOG's Committee on Adolescent Health Care."Girls need to be helped to see themselves in a successful, healthy future, and to create goals to get there." Concurring was Machelle H. Allen, MD, assistant professor of ob-gyn at New York University School of Medicine, who addressed the subject of substance abuse.

Healthier lifestyles needed

Mona M. Shangold, MD, director of the Center for Women's Health and Sports Gynecology in Philadelphia, noted that adolescent girls "should be encouraged to eat healthy, nutritious meals and exercise regularly." Owen C. Montgomery, MD, assistant professor of ob-gyn at Allegheny University of the Health Sciences in Philadelphia, discussed the issue of violence against adolescent girls and noted that physicians need to "counsel teens on sensitive subjects such as date rape and sexual assault."

ACOG messages delivered to the public

Following the New York briefing, millions of people heard the College's recommendations about teenage girls at risk. News outlets such as *USA Today* and the *CBS Morning News* provided ACOG recommendations for teen health, including a first preventive health visit to an ob-gyn at age 13–15. ■

"I am proud of this law, particularly because it goes far beyond similar laws in other states. Our law includes three additional and significant provisions: We cover all Massachusetts citizens, even [the]...approximately 50-60 percent of our insured citizens who under ERISA would not ordinarily be forced to adhere to state law. We ensure that physicians and midwives are not penalized by insurance companies and HMOs for providing appropriate care to their patient[s] and we direct our state health department to formulate regulations on early discharge and post-delivery care."

-- Massachusetts State Senator Lois Pines (D-Newton)

"This law has made an immediate and dramatic difference for women giving birth and for newborns. Mothers who need the extra recovery time are exercising their choice to stay in the hospital."

-- New Jersey Commissioner of Health Len Fishman

"The Rule provides that in addition to any other penalty provided by law or rule, violation of the provisions of the Rule is subject to penalties for violation of the Insurance Code."

-- New Mexico Department of Insurance Rule, Title 13, Chapter 10, Part 2

"This new law reflects a bi-partisan agreement that newborn babies and their mothers must be provided with enough recovery time and qualified medical supervision in the critical hours following delivery. This is an important public health measure and I applaud Governor Pataki for signing it into law."

-- New York Senate Majority Leader Joseph Bruno (R-43)

"I feel that [postpartum care] should be a decision between the doctor and the mother. I don't want insurance companies and HMOs and managed cares (sic) and hospital administrators practicing medicine without a license."

-- Ohio State Senator Grace Drake (R-Solon)

"Positive Thoughts Regarding the Eight-Hour Discharge...Benefits for Patients...Unlimited visitors at home. Hospital food is not tasty. Less blood draws when discharged home early. Less risk of nosocomial infections when hospital stay is brief. Benefits for Staff...Reduce our overhead costs to remain competitive in a fluid marketplace and thus retain our jobs and attract more patients. Less rounding (ie, less charting, less vital sign monitoring). Streamlined paperwork. Reduced education responsibilities for hospital based nurses. Greater emphasis on nursing tasks."

-- Internal memorandum, Kaiser Foundation Health Plan, Inc./Southern California Region

"The alarming trend toward premature discharge undermines the claims of HMOs that prevention is the hallmark of managed care and that HMOs can be trusted to provide high quality preventive care up front so they don't have to pay more later. Legislating quality may, unfortunately, be the legacy of managed care."

-- Jamie Court, Director, Consumers for Quality Care

STATE LEGISLATIVE
F A C T S H E E T

4/8/94

♦♦♦ NOTABLE QUOTABLES ♦♦♦
STATE LAWS AND REGULATIONS REQUIRING INSURANCE COVERAGE FOR POSTPARTUM CARE

"The routine imposition of a short and arbitrary time limit on hospital stay that does not take maternal and infant need into account could be equivalent to a large, uncontrolled, uninformed experiment that may potentially affect the health of American women and their babies. ACOG call[s] for a moratorium...a 'time-out,' on further reduction in hospital stays following delivery, until we have the data that clearly demonstrate the safety of early discharge for women and their babies."

-- American College of Obstetricians and Gynecologists press release

"Senate Bill 193 does not require a mother and newborn to stay in the hospital for 48 hours, it merely provides the coverage if it is needed....I'm not advocating for an increase in time spent in the hospital. I am concerned that the length of stay will continue to drop beyond the current levels without any data supporting shorter stays."

-- Alaska State Senator Judith Salo (D-Kenai)

"...my survey of 20 companies found that only 4 insurers provided insurance coverage for hospital stays of more than 24 hours after childbirth....[A]lthough many insurers provide coverage for more than 24 hours after childbirth if medically necessary, some insurers apply sanctions to physicians who request hospital stays beyond that of the average....[M]y survey shows that no insurers inform the mother or father of policy limit presumptions for post childbirth hospital stays....The legislation...is absolutely essential to preserving the best care for our mothers and newborns."

-- Connecticut Attorney General Richard Blumenthal (D)

"It is crucial in our system of fair play that we don't allow the natural desire to save money to put mothers and babies at risk. This legislation will make sure that we have our priorities right."

-- Illinois Governor Jim Edgar (R)

"I have voiced my concern about these practices, and many Kansas physicians have come forward to share their concern about similar incidents....I have joined with the AMA, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics in calling for a careful look at the consequences of early discharge on this vulnerable population....What concerns me is that dollars, not common sense, are driving these decisions. In the name of cost savings we may be putting moms and babies in a risky health situation. I am serious about taking a close look at the Kansas experience."

-- Kansas Insurance Commissioner Kathleen Sebelius (D)

"What we wanted [the 1995 law] to do is have the doctor exercise independent judgment and say, 'This one doesn't need to be in 48 hours and this one does.' It doesn't look like that is what is happening in the real world....I think we made a mistake."

-- Maryland State Senator Barbara Hoffman (D-Baltimore)

Department of Government Relations
American College of Obstetricians and Gynecologists
409 12th Street SW • PO Box 96920 • Washington, DC 20090-6920 • 202/863-1634 • FAX 202/488-3985

THE OBSTETRICIAN-GYNECOLOGIST:PRIMARY CARE PHYSICIAN

The specialty of obstetrics and gynecology is devoted to the health care of women throughout their lifetime. Primary-preventive health care is integral to services provided by obstetrician-gynecologists. These services include periodic health screening, evaluation and counseling about health and lifestyle risk behaviors, and immunization. Family planning, sexual counseling, instruction in breast self-examination, health education, instruction in health promotion, hypertension and cardiovascular surveillance, osteoporosis counseling, sexually transmissible diseases counseling, and identification of domestic violence are many of the primary-preventive services in a well-patient encounter with an ob-gyn. One of the most significant preventive health services provided by ob-gyns is prenatal care and risk assessment before and during pregnancy.

For many women, their ob-gyn serves as their primary care physician. As the health care delivery system undergoes major changes, it is imperative that women's direct access to their ob-gyn not be limited by Congress' failure to classify ob-gyns as primary care physicians.

- Significant numbers of women view their ob-gyn as their primary or only physician. For many women, an ob-gyn is often the only physician they see regularly during their reproductive years. According to a 1993 Gallup poll, women are more likely to have had a physical examination within the last two years from an ob-gyn than from any other type of doctor (72% vs 57%) and the majority of these women consider their ob-gyn to be their primary care physician (54%).

- Family planning is a critical preventive health care service for women. According to the National Center for Health Statistics (NCHS), three-fourths of all office visits for family planning purposes in 1989 and 1990 were to ob-gyns.

- A general medical exam was the second most frequently cited purpose of patient visits to ob-gyns in 1989 and 1990, accounting for 7 million visits each year, according to NCHS data. (Prenatal visits were the most frequently cited reason for visiting an ob-gyn.)

- Women are opposed to restrictions in accessing ob-gyns. Among women who have health coverage, a Gallup poll reported that 78% can currently access their ob-gyn without going through a gatekeeper. 75% of these women would object to requirements that they be referred by another physician or "gatekeeper" before they may see their ob-gyn. Similarly, 74% of those who now have restricted access would approve of a system that would eliminate the need for referral.

- In 1987, more than 53% of women aged 15 and older who saw an ob-gyn did so to have a general checkup. Obtaining a general checkup was a more frequently cited reason for seeing an ob-gyn than it was for seeing either family physicians or internists.

- Prenatal care is an essential primary care service for pregnant women. Every year, approximately 80% of maternity care services in the United States are provided by ob-gyns.

- In a survey of employee attitudes toward health plan design, 68% of women

responded that they would be unwilling to change their ob-gyn to save money. This percentage was significantly higher than the percentage of employees willing to change other primary care physicians.

- Data from various sources consistently show that ob-gyns provide primary care services, particularly in terms of inquiry and counseling in relation to preventive risk behaviors--the true aim of prevention. In 1992, under contract from the HHS Office of Disease Prevention and Health Promotion, ACOG conducted a randomized survey of ob-gyns. The survey found that a large proportion (more than 40%) of patients cared for by ob-gyns receive a wide variety of preventive care services. Among ob-gyns who provide primary care services,
    - 85% reported that they routinely queried about family planning/preconception care
    - 71% routinely queried about sexual practices and counseled about STDs including HIV infection
    - 71% routinely queried about smoking, 55% about alcohol, and 53% about illicit drug and medication use
    - 51% queried about diet, 48% about exercise, and 33% queried about work-related health risks
    - 40% queried about emotional and behavioral function.

- Ob-gyns refer their patients less frequently than other primary care physicians, thus avoiding costly and time-consuming referrals to specialists. According to a 1991 study of physician referral rates, ob-gyns had the lowest rate at 4%, compared with rates of 7.3% for general internists and 8.4% for general and family practitioners.

- More than two-thirds (69.5%) of all visits to ob-gyns were by established patients of the physician returning for care of their condition, according to NCHS. Only 4.7% of patient visits resulted from referrals from another physician.

October 1994

48522

DISTRICT VI

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Kenosha, WI 53143-1522
Phone: (414) 658-2133
Fax: (414) 552-2902

FEB 25 1998

Pam Kahler

23 February 1998

Mike Kirby
Legislative Affairs
Wisconsin State Medical Society
PO Box 1109
Madison, WI 53701

Dear Mike,

I am sorry for the delay in sending you this information, but I wanted to get the most recent and accurate accounts of this legislation in other states. Enclosed are copies of some other states' most recent successful legislative efforts as well as Wisconsin's effort in 1995.

At this point I think the Wisconsin OB/GYN community would like to pursue a direct access amendment and not a primary care amendment. The points of utmost importance for this amendment are as follows:

1. direct access of Wisconsin women to OB/GYN physicians for obstetrical care
2. direct access of Wisconsin women to OB/GYN physicians for both preventive and problem oriented gynecologic care
3. no negative or restrictive contract implications to the patient or physician who seeks/provides direct access care
4. obligatory notification by the insurer to all female insurees of the availability of the direct access option

The specific wording of these ideas can readily be seen in the statues that I provided. I am sure that our mutual friend at the ACOG National Office, Kathryn Moore, could help frame a document with these ideas. She could also provide ideas and wording that would avoid any potential pitfalls or loopholes.

Sincerely,

[signature] MD

Texas 75th Legislature -- Regular Session
1997 TX S 54
Enacted
970618
Shapiro
Bill Number: TX75RSB 54 Date: 6/18/97
ENROLLED

AN ACT

relating to access to certain obstetrical or gynecological health care under a health benefit plan; providing administrative penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter E, Chapter 21, Insurance Code, is amended by adding Article 21.53D to read as follows:

[A> Art. 21.53D. ACCESS TO CERTAIN OBSTETRICAL OR GYNECOLOGICAL CARE <A]

[A> Sec. 1. DEFINITIONS. In this article: <A]

[A> (1) "Enrollee" means an individual enrolled in a health benefit plan. <A]

[A> (2) "Health benefit plan" means a plan described in Section 2 of this article. <A]

[A> (3) "Physician" means a person licensed as a physician by the Texas State Board of Medical Examiners. <A]

[A> Sec. 2. SCOPE OF ARTICLE. (a) This article applies to a health benefit plan that: <A]

[A> (1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including: <A]

[A> (A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by: <A]

[A> (i) an insurance company; <A]

[A> (ii) a group hospital service corporation operating under Chapter 20 of this code; <A]

[A> (iii) a fraternal benefit society operating under Chapter 10 of this code; <A]

[A> (iv) a stipulated premium insurance company operating under Chapter 22 of this code; or <A]

[A> (v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); and <A]

[A> (B) to the extent permitted by the Employee Retirement Income

Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by: <A]

[A> (i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or <A]

[A> (ii) another analogous benefit arrangement; <A]

[A> (2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code; or <A]

[A> (3) is offered by any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis. <A]

[A> (b) Notwithstanding Section 172.014, Local Government Code, or any other law, this article applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code. <A]

[A> (c) This article does not apply to: <A]

[A> (1) a plan that provides coverage: <A]

[A> (A) only for a specified disease; <A]

[A> (B) only for accidental death or dismemberment; <A]

[A> (C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or <A]

[A> (D) as a supplement to liability insurance; <A]

[A> (2) a plan written under Chapter 26 of this code; <A]

[A> (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss); <A]

[A> (4) workers' compensation insurance coverage; <A]

[A> (5) medical payment insurance issued as a part of a motor vehicle insurance policy; <A]

[A> (6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section; <A]

[A> (7) any health benefit plan that does not provide pregnancy-related benefits; or <A]

[A> (8) any health benefit plan that does not provide well-woman care benefits. <A]

[A> (d) This article applies to each health benefit plan that requires an enrollee to obtain certain specialty health care services through a referral made by a primary care physician or other gatekeeper. <A]

[A> Sec. 3. ACCESS OF FEMALE ENROLLEE TO HEALTH CARE. (a) Each health benefit plan subject to this article shall permit a woman who is entitled to coverage under the plan to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist. This section does not preclude a woman from selecting a family physician, internal medicine physician, or other qualified physician to provide that care. <A]

[A> (b) The plan shall include in the classification of persons authorized to provide medical services under the plan a number of properly credentialed obstetricians and gynecologists sufficient to ensure access to the services that fall within the scope of that credential. <A]

[A> (c) This section does not affect the authority of a health benefit plan to establish selection criteria regarding other physicians who provide services through the plan. <A]

[A> Sec. 4. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN OR GYNECOLOGIST. (a) In addition to other benefits authorized by the plan, each health benefit plan shall permit a woman who designates an obstetrician or gynecologist as provided under Section 3 of this article direct access to the health care services of the designated obstetrician or gynecologist without a referral by the woman's primary care physician or prior authorization or precertification from a health benefit plan. <A]

[A> (b) The access to health care services required under this article includes, but is not limited to: <A]

[A> (1) one well-woman examination per year; <A]

[A> (2) care related to pregnancy; <A]

[A> (3) care for all active gynecological conditions; and <A]

[A> (4) diagnosis, treatment, and referral for any disease or condition within the scope of the professional practice of a properly credentialed obstetrician or gynecologist. <A]

[A> (c) A health benefit plan may not impose a copayment or deductible for direct access to the health care services of an obstetrician or gynecologist under this section unless such an additional cost is imposed for access to other health care services provided under the plan. <A]

[A> (d) This section does not affect the authority of a health benefit plan to require the designated obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. Failure to provide this information may not result in any penalty, financial or otherwise, being imposed upon the obstetrician or gynecologist or the patient by the health benefit plan if the obstetrician or gynecologist has made a reasonable and good-faith effort to provide the information to the primary care physician. <A]

[A> (e) In implementing the access required under Section 3 of this article, a health benefit plan may limit a woman enrolled in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical care. This subsection does not affect the right of the woman to select the physician who provides that care. <A]

[A> (f) A health benefit plan shall not sanction or terminate primary care physicians as a result of female enrollees' access to participating obstetricians and gynecologists under this section. <A]

[A> Sec. 5. NOTICE. Each health benefit plan shall provide to persons covered by the plan a timely written notice in clear and accurate language of the choices of types of physician providers for the direct access to health care services required by this article. <A]

[A> Sec. 6. RULES. The commissioner shall adopt rules as necessary to implement this article. <A]

[A> Sec. 7. ADMINISTRATIVE PENALTY. An insurance company, health maintenance organization, or other entity that operates a health benefit plan in violation of this article is subject to an administrative penalty as provided by Article 1.10E of this code. <A]

SECTION 2. Article 21.53D, Insurance Code, as added by Section 1 of this Act, applies only to an insurance policy, contract, or evidence of coverage delivered, issued for delivery, or renewed on or after January 1, 1998. A policy, contract, or evidence of coverage delivered, issued for delivery, or renewed before January 1, 1998, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 1997.

SECTION 4. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

COLORADO 1996
DIRECT ACCESS INSURANCE REGULATION

STATE OF COLORADO

DEPARTMENT OF REGULATORY AGENCIES
Joseph A. Garcia
Executive Director

DIVISION OF INSURANCE
Jack Ehnes
Commissioner of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202

Dr Kirkpatric

Roy Romer
Governor

Regulation 4-2-16

WOMEN'S ACCESS TO OBSTETRICIANS AND GYNECOLOGISTS UNDER MANAGED CARE PLANS

I. AUTHORITY

This regulation is promulgated pursuant to Section 10-1-109 and 10-16-107(5)(b), Colorado Revised Statutes (C.R.S.).

II. PURPOSE

The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Section 10-16-107(5), C.R.S., concerning women's access to obstetricians and gynecologists in managed care plans.

III. APPLICABILITY AND SCOPE

The provisions of this regulation shall apply to all managed care plans that provide coverage for reproductive health or gynecological care. "Managed care plan" is defined in Section 10-16-102(26.5), C.R.S. Examples of managed care plans include but are not limited to: preferred provider plans, gatekeeper plans, health maintenance organization plans, plans offered by limited service licensed provider networks, and plans that provide better coverage (e.g., pay a greater percentage of covered expenses or have lower copayment requirements) if a covered person uses specified providers (sometimes called participating or in-network providers).

IV. DEFINITION

A. "Reproductive health and gynecological care" means care for both the normal and abnormal processes of the female reproductive system, including medical and surgical management of disorders, pregnancy and childbirth, and related preventive care.

V. RULES

A. Effective January 31, 1997, a managed care plan that provides coverage for reproductive health or gynecological care shall not be issued or renewed unless such plan either provides a woman covered under the plan direct access to an obstetrician or gynecologist for her reproductive or gynecological care or has referral procedures in place that comply with this regulation.

B. A managed care plan will be considered to have provided "direct access" to an obstetrician or gynecologist for her reproductive and gynecological care only if a woman covered under the plan has the option of selecting a participating obstetrician or gynecologist who is available under the plan as her primary care provider, or :

1. Can herself directly make an appointment with an obstetrician or gynecologist who is participating and available under the plan;

2. Is not required as a condition of coverage to get prior approval or a referral from her primary care provider, the managed care plan, a representative of the managed care plan, or any other entity for an appointment/visit with an obstetrician or gynecologist who is participating and available under the plan; and

3. Is not required to pay more out-of-pocket for directly accessing an obstetrician or gynecologist who is participating and available under the plan than if she received prior approval for, or a primary care provider referral to, such an obstetrician or gynecologist.

C. A managed care plan that does not provide direct access pursuant to subsection B shall have procedures in place to ensure that a woman covered under the plan who requests a referral to, or reauthorization of care provided by, an obstetrician or gynecologist participating and available under the plan for her reproductive and gynecological care shall not have such referral or reauthorization unreasonably withheld. Such procedures shall be in writing, shall be provided upon request and at no charge to the Division of Insurance, a covered person, or a participating provider, and shall make provision for the following:

1. A request for a referral or reauthorization may be made orally (e.g., by telephone) or in writing, at the discretion of the covered woman making the request. The managed care plan's procedures shall specify whether the request should be submitted to the plan or to the primary care provider, or whether either may receive the request.

2. A managed care plan may require that a request by a woman for a referral to, or reauthorization of care provided by, a participating obstetrician or gynecologist include the following information only:

   a. The reason for the request for referral or reauthorization of care and the type of care being sought (e.g., ongoing gynecological care, prenatal care, etc.), **including sufficient information to determine if referral services requested are a benefit under the plan;**

   b. The number of visits or period for which the referral or reauthorization is being requested (e.g., for one visit, for all obstetrical care throughout the term of a pregnancy, etc.); and

   c. Identifying information (e.g., name of primary care provider, name of the obstetrician or gynecologist to whom the woman wants a referral, plan number, enrollee name, etc.).

3. A request for a referral or reauthorization shall be approved or denied within three (3) working days of the date on which the request was made if it is an oral request, or within three (3) working days of the date on which it was received if it is a written request. Where a plan allows a primary care provider to process referral requests, pursuant to Section V.C.1. of this regulation, the same timelines shall apply.

4. An approval of a request by a woman for a referral to, or reauthorization of care provided by, a participating obstetrician or gynecologist shall include, at minimum, the following information:

   a. The number of visits or period for which the referral or reauthorization is being approved (e.g., for one visit, for all obstetrical care throughout the term of a pregnancy, etc.); and

   b. The plan's understanding of the reason for the referral (e.g., ongoing gynecological care, prenatal care, etc.).

5. Approvals and denials of requests may be made orally but all denials shall be followed up by the health coverage plan or its representative within eight (8) working days of the receipt of the original oral or written request with a detailed written explanation of the reason(s) for the denial. The written denial shall also

describe the process by which the covered person may appeal and/or file a grievance concerning the denial.

6. Managed care plans shall not financially penalize, sanction, terminate, or reward a participating provider responsible for making referrals based on the volume and/or consequent expenditures incurred as a result of that provider's referrals to participating obstetricians or gynecologists made pursuant to this regulation.

7. A managed care plan or its representative shall not deny a request for a referral to, or reauthorization of care by, a participating obstetrician or gynecologist solely because a covered woman's primary care provider is able/qualified to provide the same reproductive health or gynecological care, treatment or diagnostic tests as the obstetrician or gynecologist.

8. Managed care plans may require an obstetrician or gynecologist to whom a woman has been referred to send information concerning care for the woman to her primary care provider, in order to promote ongoing management of her care and continuity of care. However, failure of an obstetrician or gynecologist to provide such information shall not in any way result in financial or other penalties being imposed by the plan on either the patient or the primary care provider.

D. All managed care plans subject to subsection C shall keep a log on file of all denied requests for referrals to, and denials of reauthorizations of care provided by, an obstetrician or gynecologist who is participating and available under the plan that have been appealed. The log shall indicate the date of each request, the reason for each denial, and the final outcome of each appeal. The log of denied requests that have been appealed shall not include patient identifying information. The log shall be made available upon request to the Division of Insurance.

E. Nothing in this regulation shall be construed to require a managed care plan to make or approve a referral to an obstetrician or gynecologist who is not a participating physician under the plan. Also, nothing in this regulation shall be construed to require a managed care plan to include in its plan of coverage specific obstetrical or gynecological services, except to the extent otherwise required by law or regulation.

VI. ENFORCEMENT

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the

business of insurance or other laws which include the imposition of penalties, issuance of cease and desist orders, and/or suspensions or revocations of license.

VII. SEVERABILITY

If any provision of this regulation or the application thereof to any person or circumstance is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or unenforceability shall not affect the other provisions, and this regulation is expressly declared to be severable.

VIII. EFFECTIVE DATE

This regulation is effective on December 30, 1996 and shall apply to health coverage plans issued or renewed on or after January 31, 1997.

Colorado - 1996
Ob/Gyn -- Primary Care/Direct Access

1996

An Act

HOUSE BILL 96-1082

BY REPRESENTATIVES Friednash, Armstrong, Chlouber, Clarke, Epps, Hagedorn, Knox, Kreutz, Leyba, Lyle, Morrison, Sullivan, Sullivant, and Tool;
also SENATORS Hopper, Dennis, Hernandez, Martinez, Matsunaka, Pascoe, L. Powers, Tanner, Wattenberg, Weddig, Weissmann, and Wham.

CONCERNING COVERAGE UNDER A HEALTH BENEFIT PLAN OF HEALTH CARE SERVICES RELATED TO A WOMAN'S REPRODUCTIVE SYSTEM PROVIDED BY PARTICIPATING PHYSICIANS WHO ROUTINELY PRACTICE WOMEN'S REPRODUCTIVE SYSTEM HEALTH CARE.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 10-16-102, Colorado Revised Statutes, 1994 Repl. Vol., is amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS to read:

10-16-102. Definitions. As used in this article, unless the context otherwise requires:

(22.5) "HEALTH COVERAGE PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT ENTERED INTO BY, OFFERED TO, OR ISSUED BY A CARRIER TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

(26.5) "MANAGED CARE PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT OFFERED BY A CARRIER TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES THROUGH THE COVERED PERSON'S USE OF HEALTH CARE PROVIDERS MANAGED BY, OWNED BY, UNDER CONTRACT WITH, OR

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

EMPLOYED BY THE CARRIER BECAUSE THE CARRIER EITHER REQUIRES THE USE OF OR CREATES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR THE COVERED PERSON'S USE OF THOSE PROVIDERS.

SECTION 2. 10-16-107, Colorado Revised Statutes, 1994 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-107. Rate regulation - approval of policy forms - benefit certificates - evidences of coverage - loss ratio guarantees. (5) EFFECTIVE JANUARY 31, 1997, A MANAGED CARE PLAN THAT PROVIDES COVERAGE FOR REPRODUCTIVE HEALTH OR GYNECOLOGICAL CARE SHALL NOT BE ISSUED OR RENEWED UNLESS SUCH PLAN EITHER:

(a) PROVIDES A WOMAN COVERED BY THE PLAN DIRECT ACCESS TO AN OBSTETRICIAN OR GYNECOLOGIST PARTICIPATING AND AVAILABLE UNDER THE PLAN FOR HER REPRODUCTIVE HEALTH CARE OR GYNECOLOGICAL CARE; OR

(b) (I) SUBJECT TO RULES PROMULGATED BY THE COMMISSIONER, HAS PROCEDURES IN PLACE THAT ENSURE THAT, IF A WOMAN COVERED BY THE PLAN REQUESTS A TIMELY REFERRAL TO AN OBSTETRICIAN OR GYNECOLOGIST PARTICIPATING AND AVAILABLE UNDER THE PLAN FOR HER REPRODUCTIVE HEALTH AND GYNECOLOGICAL CARE, THE REQUEST FOR REFERRAL SHALL NOT BE UNREASONABLY WITHHELD. SUCH RULES SHALL INCLUDE, BUT NEED NOT BE LIMITED TO, THE FOLLOWING ISSUES:

(A) WHAT CONSTITUTES A TIMELY REFERRAL;

(B) CIRCUMSTANCES, PRACTICES, POLICIES, CONTRACT PROVISIONS, OR ACTIONS THAT CONSTITUTE AN UNDUE OR UNREASONABLE INTERFERENCE WITH THE ABILITY OF A WOMAN TO SECURE A REFERRAL OR REAUTHORIZATION FOR CONTINUING CARE;

(C) THE PROCESS FOR ISSUING A DENIAL OF A REQUEST, INCLUDING THE MEANS BY WHICH A WOMAN MAY OBTAIN SUCH A DENIAL AND THE REASONS THEREFOR IN WRITING;

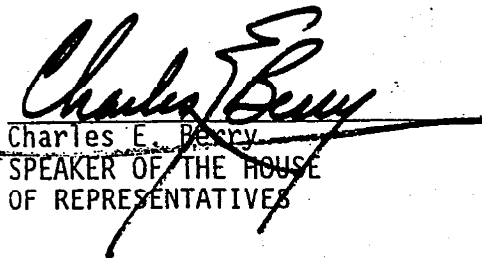
(D) ACTIONS THAT CONSTITUTE IMPROPER PENALTIES IMPOSED UPON PRIMARY PROVIDERS AS A RESULT OF REFERRALS MADE PURSUANT TO THIS SUBSECTION (5); AND

(E) SUCH OTHER ISSUES THE COMMISSIONER DEEMS NECESSARY.

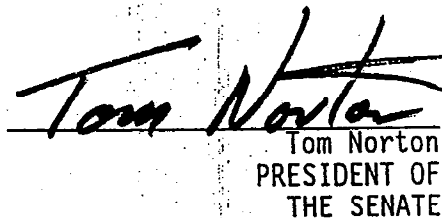
(II) IN DEVELOPING RULES PURSUANT TO THIS SUBSECTION (5), THE COMMISSIONER SHALL CONSULT WITH PROVIDERS, INCLUDING, BUT NOT LIMITED TO, FAMILY CARE PHYSICIANS, REPRESENTATIVES OF HEALTH PLANS, AND OTHER APPROPRIATE PERSONS AND MAY CONDUCT SUCH SURVEYS AND ANALYSES AS MAY BE NECESSARY TO DEVELOP THE REGULATION.

SECTION 3. Effective date - applicability. This act shall take effect July 1, 1996, and shall apply to health coverage plans issued or renewed on or after January 31, 1997.

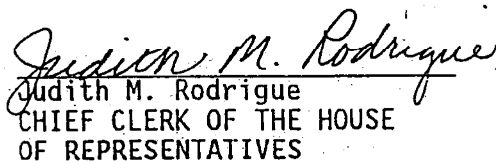
SECTION 4. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.



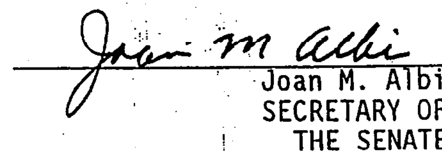
Charles E. Berry
SPEAKER OF THE HOUSE
OF REPRESENTATIVES



Tom Norton
PRESIDENT OF
THE SENATE

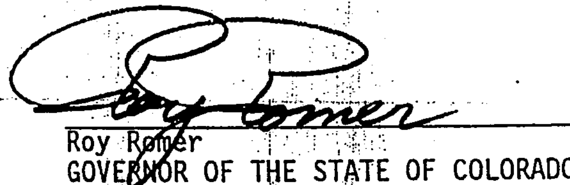


Judith M. Rodrigue
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES



Joan M. Albi
SECRETARY OF
THE SENATE

APPROVED May 22, 1996 at 3:30 P.M.



Roy Romer
GOVERNOR OF THE STATE OF COLORADO

CHAPTER No. 26
H.F. No. 447

AN ACT

Distributed By
Secretary of the SENATE
Room 231, State Capitol
St. Paul, 296-2343

1

2 relating to insurance; requiring health plan companies
3 to provide direct access to obstetric and gynecologic
4 services; proposing coding for new law in Minnesota
5 Statutes, chapter 62Q.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

7 Section 1. [62Q.52] [DIRECT ACCESS TO OBSTETRIC AND
8 GYNECOLOGIC SERVICES.]

9 (a) Health plan companies shall allow female enrollees
10 direct access to obstetricians and gynecologists for the
11 following services:

12 (1) annual preventive health examinations, which shall
13 include a gynecologic examination, and any subsequent obstetric
14 or gynecologic visits determined to be medically necessary by
15 the examining obstetrician or gynecologist, based upon the
16 findings of the examination;

17 (2) maternity care; and

18 (3) evaluation and necessary treatment for acute
19 gynecologic conditions or emergencies.

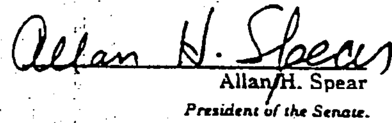
20 (b) For purposes of this section, "direct access" means
21 that a female enrollee may obtain the obstetric and gynecologic
22 services specified in paragraph (a) from obstetricians and
23 gynecologists in the enrollee's network without a referral from,
24 or prior approval through, another physician, the health plan
25 company, or its representatives.

1 (c) Health plan companies shall not require higher
2 copayments, coinsurance, deductibles, or other enrollee
3 cost-sharing for direct access.
4 (d) This section applies only to services described in
5 paragraph (a) that are covered by the enrollee's coverage, but
6 coverage of a preventive health examination for female enrollees
7 must not exclude coverage of a gynecologic examination.
8 Sec. 2. [EFFECTIVE DATE.]
9 Section 1 is effective January 1, 1998, and applies to
10 coverage issued or renewed on or after that date.

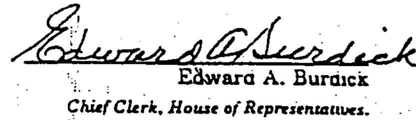
CHAPTER No. 26
H.F. No. 447

This bill was passed in conformity to the rules of each house and the joint rules of the two houses as required by the Constitution of the State of Minnesota.

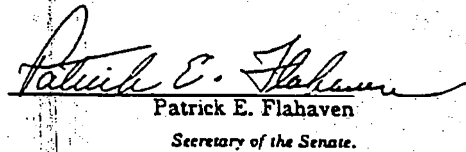
Philip C. Carruthers
Speaker of the House of Representatives.


Allan H. Spear
President of the Senate.

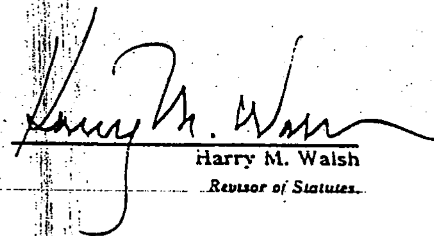
Passed the House of Representatives on February 24, 1997.


Edward A. Burdick
Chief Clerk, House of Representatives.

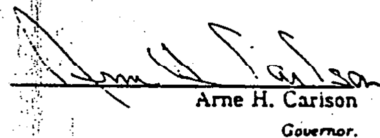
Passed the Senate on April 3, 1997.


Patrick E. Flahaven
Secretary of the Senate.

This bill is properly enrolled and was presented to the Governor on April 7, 1997.


Harry M. Walsh
Revisor of Statutes.

Approved on April 8, 1997, at 10:30 a. M.


Arne H. Carlson
Governor.

Filed on April 8, 1997.

Joan Anderson Growe
Secretary of State.

1 AN ACT *to amend* 40.51 (9), 185.981 (7), 609.05 (2) and 609.05 (3); and *to create*
2 609.62 of the statutes; **relating to:** prohibiting referral requirement for obstet-
3 ric or gynecological services.

Analysis by the Legislative Reference Bureau

Under current law, health maintenance organizations, limited service health organizations and preferred provider plans (health care plans) require enrolled participants to obtain health care services from health care providers that are selected by the health care plan (selected providers). A health care plan may require an enrolled participant to designate a primary provider from among its selected providers, obtain health care services from the primary provider whenever reasonably possible and obtain a referral from the primary provider to another selected provider before obtaining services from that other selected provider. This bill provides that a health care plan must allow a female enrolled participant to obtain obstetric or gynecological services from a selected provider who is a physician specializing in obstetrics and gynecology without having first obtained a referral to that selected provider, even if that selected provider is not the woman's primary provider. A health care plan must provide written notice of the requirement in its policies and group certificates and to each female enrolled participant and each female applicant for coverage at open enrollment time.

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

4 **SECTION 1.** 40.51 (9) of the statutes is amended to read:
5 40.51 **(9)** Every health maintenance organization and preferred provider plan
6 offered by the state under sub. (6) shall comply with s ss. 609.62 and 632.87 (2m).

1 SECTION 2. 185.981 (7) of the statutes is amended to read:

2 185.981 **(7)** Notwithstanding sub. (4) and s. 185.982 (1), a sickness care plan
3 that is operated by a cooperative association and that qualifies as a health mainte-
4 nance organization, as defined in s. 609.01 (2), is subject to ~~s~~ ss. 609.62 and 609.655.

5 SECTION 3. 609.05 (2) of the statutes is amended to read:

6 609.05 **(2)** ~~A~~ Except as provided in s. 609.62, a health care plan under sub. (1)
7 may require an enrolled participant to designate a primary provider and to obtain
8 health care services from the primary provider when reasonably possible.

9 SECTION 4. 609.05 (3) of the statutes is amended to read:

10 609.05 **(3)** Except as provided in ss. 609.62, 609.65 and 609.655, a health care
11 plan under sub. (1) may require an enrolled participant to obtain a referral from the
12 primary provider designated under sub. (2) to another selected provider prior to ob-
13 taining health care services from the other selected provider.

14 SECTION 5. 609.62 of the statutes is created to read:

15 **609.62 Obstetric and gynecological services. (1)** A health maintenance
16 organization, limited service health organization or preferred provider plan shall al-
17 low a female enrolled participant to obtain obstetric or gynecological services from
18 a selected provider who is a physician licensed under ch. 448 and who specializes in
19 obstetrics and gynecology without first having obtained a referral to that selected
20 provider, regardless of whether that selected provider is the enrolled participant's
21 primary provider.

22 **(2)** A health care plan under sub. (1) shall provide written notice of the require-
23 ment under sub. (1) in each policy or group certificate issued by the health care plan

1 and, during each open enrollment period, to each female enrolled participant and
2 each female applicant for coverage.
3 (END)

State of Wisconsin
1999 – 2000 LEGISLATURE

LRB–2664/1
PJK...:...:...

jlg

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

D-note

WPO - check auto refs

gen cat

1 AN ACT ...; **relating to:** prohibiting managed care plans from requiring referrals
2 for obstetric or gynecologic services.

Analysis by the Legislative Reference Bureau

Under current law, a managed care plan (which is a health benefit plan that requires or creates incentives for an enrollee to obtain health care services from providers under contract with or employed by the health benenfit plan) may require an enrollee to designate a primary provider from among its participating providers, to obtain health care services from the primary provider whenever reasonably possible and to obtain a referral from the primary provider to another participating provider before obtaining services from that other participating provider. However, current law also requires a managed care plan to establish a procedure whereby an enrollee may obtain a standing referral to obtain services from a participating provider who is a specialist.

This bill provides that a managed care plan that covers obstetric or gynecologic services must cover those services if obtained from a participating provider who is a physician specializing in obstetrics and gynecology by a female enrollee without a referral, even if that participating provider is not the female enrollee's primary provider. In addition, the managed care plan may not require the female enrollee to obtain a standing referral to the participating provider for the coverage. The bill provides that a managed care plan may not penalize or restrict a female enrollee's coverage on account of her having obtained the services without a referral and may not penalize or restrict the contract of a provider on account of his or her having provided the services without a referral. A managed care plan must provide written

notice of the requirement in its policies and group certificates and, at open enrollment time, to each female enrollee and each female applicant for coverage.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

1 **SECTION 1.** 609.05 (2) of the statutes is amended to read:

2 609.05 **(2)** Subject to s. 609.22 (4) and (4m), a limited service health
3 organization, preferred provider plan or managed care plan may require an enrollee
4 to designate a primary provider and to obtain health care services from the primary
5 provider when reasonably possible.

History: 1985 a. 29; 1987 a. 366; 1989 a. 121; 1997 a. 237.

6 **SECTION 2.** 609.05 (3) of the statutes is amended to read:

7 609.05 **(3)** Except as provided in ss. 609.22 (4m), 609.65 and 609.655, a limited
8 service health organization, preferred provider plan or managed care plan may
9 require an enrollee to obtain a referral from the primary provider designated under
10 sub. (2) to another participating provider prior to obtaining health care services from
11 that participating provider.

12 **SECTION 3.** 609.22 (4m) of the statutes is created to read:

13 609.22 **(4m)** OBSTETRIC AND GYNECOLOGIC SERVICES. (a) A managed care plan
14 that provides coverage of obstetric or gynecologic services may not require a female
15 enrollee of the managed care plan to obtain a referral for coverage of those services
16 provided by a participating provider who is a physician licensed under ch. 448 and
17 who specializes in obstetrics and gynecology, regardless of whether the participating
18 provider is the enrollee's primary provider. Notwithstanding sub. (4), the managed
19 care plan may not require the enrollee to obtain a standing referral under the

1 procedure established under sub. (4) (a) for coverage of the services specified in this
2 ~~subsection~~ → paragraph
3 (b) A managed care plan under par. (a) may not do any of the following:
4 1. Penalize or restrict the coverage of a female enrollee on account of her having
5 obtained obstetric or gynecologic services in the manner provided under par. (a).
6 2. Penalize or restrict the contract of a participating provider on account of his
7 or her having provided obstetric or gynecologic services in the manner provided
8 under par. (a).
9 (c) A managed care plan under par. (a) shall provide written notice of the
10 requirement under par. (a) in each policy or group certificate issued by the managed
11 care plan and, during each open enrollment period, to each female enrollee and each
12 female applicant for coverage.
13 **SECTION 4. Initial applicability.**
14 (1) This act first applies to all of the following:
15 (a) Except as provided in paragraph (b), policies and group certificates that are
16 issued or renewed on the effective date of this paragraph.
17 (b) Policies and group certificates covering employes who are affected by a
18 collective bargaining agreement containing provisions inconsistent with this act
19 that are issued or renewed on the earlier of the following:
20 1. The day on which the collective bargaining agreement expires.
21 2. The day on which the collective bargaining agreement is extended, modified
22 or renewed.
23 **SECTION 5. Effective date.**

1 (1) This act takes effect on the first day of the 6th month beginning after
2 publication.

3 (END)

D-note

Drafter's Note
from the
Legislative Reference Bureau

This draft contains the usual initial applicability and effective date provisions that apply in bills that contain an insurance mandate. Because this bill does not require an insurance company to provide additional coverage, as does the usual insurance mandate, you may not want the usual initial applicability and effective date provisions. Another possibility would be to require compliance at renewal (as opposed to immediately) only if a policy or certificate contains terms or provisions that conflict with the requirement under the bill.

Let me know if you want the initial applicability or effective date provision, or anything else, changed.

PJK

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2664/1dn
PJK:jlg:ijs

April 8, 1999

This draft contains the usual initial applicability and effective date provisions that apply in bills that contain an insurance mandate. Because this bill does not require an insurance company to provide additional coverage, as does the usual insurance mandate, you may not want the usual initial applicability and effective date provisions. Another possibility would be to require compliance at renewal (as opposed to immediately) only if a policy or certificate contains terms or provisions that conflict with the requirement under the bill.

Let me know if you want the initial applicability or effective date provision, or anything else, changed.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: Pam.Kahler@legis.state.wi.us

State of Wisconsin
1999 – 2000 LEGISLATURE

LRB–2664/2
PJK:jlg:ijs

rm rem

1999 BILL

WPO - check auto refs

Regen

1 AN ACT *to amend* 609.05 (2) and 609.05 (3); and *to create* 609.22 (4m) of the
2 statutes; **relating to:** prohibiting managed care plans from requiring referrals
3 for obstetric or gynecologic services.

Analysis by the Legislative Reference Bureau

Under current law, a managed care plan (which is a health benefit plan that requires or creates incentives for an enrollee to obtain health care services from providers under contract with or employed by the health benefit plan) may require an enrollee to designate a primary provider from among its participating providers, to obtain health care services from the primary provider whenever reasonably possible and to obtain a referral from the primary provider to another participating provider before obtaining services from that other participating provider. However, current law also requires a managed care plan to establish a procedure whereby an enrollee may obtain a standing referral to obtain services from a participating provider who is a specialist.

This bill provides that a managed care plan that covers obstetric or gynecologic services must cover those services if obtained from a participating provider who is a physician specializing in obstetrics and gynecology by a female enrollee without a referral, even if that participating provider is not the female enrollee's primary provider. In addition, the managed care plan may not require the female enrollee to obtain a standing referral to the participating provider for the coverage. The bill provides that a managed care plan may not penalize or restrict a female enrollee's coverage on account of her having obtained the services without a referral and may

not penalize or restrict the contract of a provider on account of his or her having provided the services without a referral. A managed care plan must provide written notice of the requirement in its policies and group certificates and, at open enrollment time, to each female enrollee and each female applicant for coverage.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

1 **SECTION 1.** 609.05 (2) of the statutes is amended to read:

2 609.05 **(2)** Subject to s. 609.22 (4) and (4m), a limited service health
3 organization, preferred provider plan or managed care plan may require an enrollee
4 to designate a primary provider and to obtain health care services from the primary
5 provider when reasonably possible.

6 **SECTION 2.** 609.05 (3) of the statutes is amended to read:

7 609.05 **(3)** Except as provided in ss. 609.22 (4m), 609.65 and 609.655, a limited
8 service health organization, preferred provider plan or managed care plan may
9 require an enrollee to obtain a referral from the primary provider designated under
10 sub. (2) to another participating provider prior to obtaining health care services from
11 that participating provider.

12 **SECTION 3.** 609.22 (4m) of the statutes is created to read:

13 609.22 **(4m)** OBSTETRIC AND GYNECOLOGIC SERVICES. (a) A managed care plan
14 that provides coverage of obstetric or gynecologic services may not require a female
15 enrollee of the managed care plan to obtain a referral for coverage of those services
16 provided by a participating provider who is a physician licensed under ch. 448 and
17 who specializes in obstetrics and gynecology, regardless of whether the participating
18 provider is the enrollee's primary provider. Notwithstanding sub. (4), the managed
19 care plan may not require the enrollee to obtain a standing referral under the

1 procedure established under sub. (4) (a) for coverage of the services specified in this
2 paragraph.
3 (b) A managed care plan under par. (a) may not do any of the following:
4 1. Penalize or restrict the coverage of a female enrollee on account of her having
5 obtained obstetric or gynecologic services in the manner provided under par. (a).
6 2. Penalize or restrict the contract of a participating provider on account of his
7 or her having provided obstetric or gynecologic services in the manner provided
8 under par. (a).
9 (c) A managed care plan under par. (a) shall provide written notice of the
10 requirement under par. (a) in each policy or group certificate issued by the managed
11 care plan and, during each open enrollment period, to each female enrollee and each
12 female applicant for coverage.
13 SECTION 4. Initial applicability.
14 (1) This act first applies to all of the following:
15 (a) Except as provided in paragraph (b), policies and group certificates that are
16 issued or renewed on the effective date of this paragraph.
17 (b) Policies and group certificates covering employes who are affected by a
18 collective bargaining agreement containing provisions inconsistent with this act
19 that are issued or renewed on the earlier of the following:
20 (a) 1. The day on which the collective bargaining agreement expires.
21 (b) 2. The day on which the collective bargaining agreement is extended, modified
22 or renewed.
23 SECTION 5. Effective date.

Insert 3-19

OVER

1 (1) This act takes effect on the first day of the 6th month beginning after
2 publication.

3 (END)

INSERT 3–19

SECTION 1. Initial applicability.

a.r.

(1) INCONSISTENT PROVISIONS. Except as provided in subsection (2), if a policy or certificate that is affected by this act and that is in effect on the effective date of this subsection contains terms or provisions that are inconsistent with this act, this act first applies to that policy or certificate upon renewal.

(2) COLLECTIVE BARGAINING AGREEMENT WITH INCONSISTENT PROVISIONS. This act first applies to policies and group certificates covering employes who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

(END OF INSERT 3–19)

SUBMITTAL FORM

LEGISLATIVE REFERENCE BUREAU
Legal Section Telephone: 266-3561
5th Floor, 100 N. Hamilton Street

The attached draft is submitted for your inspection. Please check each part carefully, proofread each word, and **sign** on the appropriate line(s) below.

Date: 4/13/99

To: Representative Sinicki

Relating to LRB drafting number: LRB-2664

Topic
Require health care plans to allow services by certain providers without referral

Subject(s)
Insurance - health

1. **JACKET** the draft for introduction Chris

   in the **Senate** ____ or the **Assembly** X (check only one). Only the requester under whose name the drafting request is entered in the LRB's drafting records may authorize the draft to be submitted. Please allow one day for the preparation of the required copies.

2. **REDRAFT.** See the changes indicated or attached ______________.

   A revised draft will be submitted for your approval with changes incorporated.

3. Obtain **FISCAL ESTIMATE NOW**, prior to introduction X.

   If the analysis indicates that a fiscal estimate is required because the proposal makes an appropriation or increases or decreases existing appropriations or state or general local government fiscal liability or revenues, you have the option to request the fiscal estimate prior to introduction. If you choose to introduce the proposal without the fiscal estimate, the fiscal estimate will be requested automatically upon introduction. It takes about 10 days to obtain a fiscal estimate. Requesting the fiscal estimate prior to introduction retains your flexibility for possible redrafting of the proposal.

If you have any questions regarding the above procedures, please call 266-3561. If you have any questions relating to the attached draft, please feel free to call me.

Pamela J. Kahler, Senior Legislative Attorney
Telephone: (608) 266-2682