LRBb1515

2001 DRAFTING REQUEST

Assembly Amendment (AA-ASA1-SB55)

Received: **06/22/2001**

Received By: **kahlepj**

Wanted: **Soon**

Identical to LRB:

For: **Assembly Republican Caucus**

By/Representing: **Hughes**

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

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Pre Topic:

ARC:.....Hughes - AM66,

Topic:

Preferred provider plans

Instructions:

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Budget Amendments 2001 - 2003

Prepared by the Assembly Republican Caucus

Statement of Intent Preferred Provider Plan

Legislator	Montgomery	**Amendment**	66
Legislator 2	Underheim	**Pass or Fail**	Pass
Legislator 3		**Spending Cut**	
Legislator 4		**Withdrawn**	
Staff contact	Rose	**Package**	
Agency	Insurance		

Summary The term "managed care plan" will be changed to "defined network plan" throughout the statutes.

2. 609.24 continuity of care. A provision will be added requiring that a defined network plan (not just a PPP) either must notify enrollees of their continuity of care rights when a provider terminates participation in the plan or must require, by contract, participating providers to notify enrollees.

3. 609.32 quality assurance. Sub. (1) will begin: "A defined network plan that is not a PPP shall . . ." A new sub. (1m) will be added to read: "(1m) A PPP shall develop a procedure for remedial action to address quality problems, including written procedures for taking appropriate corrective action." All defined network plans would still be subject to sub. (2).

4. 609.34 medical director. The current section would become sub. (1). A new sub. (2) would be added that would be based on LRB-2579/3, page 9, lines 9 to 14, except that it would begin "Notwithstanding sub. (1),"; and "or its designee" would be added after "plan" on lines 11 and 12.

5. 609.20 rules. Current (intro.) and (1) to (4) would become (1)(intro.) and (a) to (d). A new sub. (2m) would be added, based on LRB-2579/3, page 7, lines 15 to 19, except that on line 15, "section" would be changed to "chapter" and on line 16, "managed care plans" would be changed to "other types of defined network plans".

6. 609.22 access standards. Current sub. (1) would be amended to read: "(1) A defined network plan shall include a sufficient number, and sufficient types of qualified providers to meet the anticipated needs of its enrollees, with respect to covered benefits and geographic norms and that are appropriate to the type of plan." Current subs. (2), (3), (4), and (7) would not apply to PPPs; e.g. "(2) A defined network plan that is not a PPP shall . . ."

7. 609.01(4) definition of "PPP". The current definition would be modified by adding "without referral and " after "to its enrollees' and by amending the last part of the definition to read" " . . .fixed payments, coverage of either comprehensive health care services or a limited range of health care services, with the services covered being the same whether performed by participating or nonparticipating providers."

In addition, if the Senate restores the point-of-service mandate, the parties agreed that PPPs should be exempted from the Point-of-Service portion of 609.10.

Fiscal Impact No fiscal impact.

Request # 334

Budget Amendments 2001 - 2003

Prepared by the Assembly Republican Caucus

Drafting Inst

ARC Analyst Hughes

Request # 334

State of Wisconsin
2001 – 2002 LEGISLATURE

LRBb1515/1
PJK:...:...
cjs

ARC:.....Hughes – AM66, Preferred provider plans

FOR 2001–03 BUDGET — NOT READY FOR INTRODUCTION

CAUCUS ASSEMBLY AMENDMENT

TO ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO 2001 SENATE BILL 55

substitute amendment

At the locations indicated, amend the ~~bill~~ as follows:

1. Page ~~7~~, line ~~7~~: after that line insert: (534 → 23)

"**SECTION ~~99~~.** 40.51 (12) of the statutes is amended to read: (1398r)

40.51 **(12)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), and every limited service health organization, as defined in s. 609.01 (3), that is offered by the state under sub. (6) shall comply with ch. 609.

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 95, 115, 155; s. 13.93 (2) (c).

~~**2.** Page ~~7~~, line ~~7~~: after that line insert:~~

SECTION ~~99~~. 40.51 (13) of the statutes is amended to read: (1398s)

40.51 **(13)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), and every limited service health organization, as defined in s. 609.01 (3), that is offered by the group insurance board under sub. (7) shall comply with ch. 609. "

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 95, 115, 155; s. 13.93 (2) (c).

3. Page ~~1~~, line ~~1~~: after that line insert:

"**SECTION ~~1~~.** Chapter 609 (title) of the statutes is amended to read:

CHAPTER 609

~~MANAGED CARE~~ DEFINED NETWORK PLANS

SECTION ~~2~~. 609.01 (1d) of the statutes is amended to read:

609.01 **(1d)** "Enrollee" means, with respect to a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization, a person who is entitled to receive health care services under the plan.

History: 1985 a. 29; 1989 a. 23; 1997 a. 237.

SECTION ~~3~~. 609.01 (3c) of the statutes is renumbered 609.01 (1b) and amended to read:

609.01 **(1b)** "~~Managed care~~ Defined network plan" means a health benefit plan that requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with, or employed by the insurer offering the health benefit plan.

History: 1985 a. 29; 1989 a. 23; 1997 a. 237.

SECTION ~~4~~. 609.01 (3m) of the statutes is amended to read:

609.01 **(3m)** "Participating" means, with respect to a physician or other provider, under contract with a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to provide health care services,

items or supplies to enrollees of the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization.

History: 1985 a. 29; 1989 a. 23; 1997 a. 237.

SECTION 2. 609.01 (4) of the statutes is amended to read:

609.01 **(4)** "Preferred provider plan" means a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, 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 ~~participating in the plan~~.

History: 1985 a. 29; 1989 a. 23; 1997 a. 237.

SECTION 3. 609.01 (5) of the statutes is amended to read:

609.01 **(5)** "Primary provider" means a participating primary care physician, or other participating provider authorized by the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to serve as a primary provider, who coordinates and may provide ongoing care to an enrollee.

History: 1985 a. 29; 1989 a. 23; 1997 a. 237.

SECTION 4. 609.05 (1) of the statutes is amended to read:

609.05 **(1)** Except as provided in subs. (2) and (3), a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall permit its enrollees to choose freely among participating providers.

History: 1985 a. 29; 1987 a. 366; 1989 a. 121; 1997 a. 237; 1999 a. 9.

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

609.05 **(2)** Subject to s. 609.22 (4) and (4m), a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan may

require an enrollee to designate a primary provider and to obtain health care services from the primary provider when reasonably possible.

History: 1985 a. 29; 1987 a. 366; 1989 a. 121; 1997 a. 237; 1999 a. 9.

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

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

History: 1985 a. 29; 1987 a. 366; 1989 a. 121; 1997 a. 237; 1999 a. 9.

SECTION 4. 609.17 of the statutes is amended to read:

609.17 Reports of disciplinary action. Every limited service health organization, preferred provider plan, and ~~managed care~~ defined network plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a participating provider who holds a license or certificate granted by the board or affiliated credentialing board.

History: 1985 a. 340; 1993 a. 107; 1997 a. 237.

SECTION 5. 609.20 (title) of the statutes is amended to read:

609.20 (title) **Rules for preferred provider and ~~managed care~~ defined network plans.**

History: 1985 a. 29; 1997 a. 237; 1999 a. 9.

SECTION 6. 609.20 (intro.) of the statutes is renumbered 609.20 (1m) (intro.) and amended to read:

609.20 **(1m)** (intro.) The commissioner shall promulgate rules relating to preferred provider plans and ~~managed care~~ defined network plans for all of the following purposes:

SECTION 2. 609.20 (1) of the statutes is renumbered 609.20 (1m) (a).

SECTION 3. 609.20 (2) of the statutes is renumbered 609.20 (1m) (b).

SECTION 4. 609.20 (2m) of the statutes is created to read:

609.20 **(2m)** Any rule promulgated under this chapter shall recognize the differences between preferred provider plans and other types of defined network plans, take into account the fact that preferred provider plans provide coverage for the services of nonparticipating providers, and be appropriate to the type of plan to which the rule applies.

SECTION 5. 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act 9, is renumbered 609.20 (1m) (c).

SECTION 6. 609.20 (4) of the statutes, as affected by 2001 Wisconsin Act 9, is renumbered 609.20 (1m) (d).

SECTION 7. 609.22 (1) of the statutes is amended to read:

609.22 **(1)** PROVIDERS. A ~~managed care~~ defined network plan shall include a sufficient number, and sufficient types, of qualified providers that are appropriate to the type of plan to meet the anticipated needs of its enrollees, with respect to covered benefits and normal practices and standards in the geographic area.

History: 1997 a. 237; 1999 a. 9

SECTION 8. 609.22 (2) of the statutes is amended to read:

609.22 **(2)** ADEQUATE CHOICE. A ~~managed care~~ defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are accessible and qualified.

History: 1997 a. 237; 1999 a. 9.

SECTION 9. 609.22 (3) of the statutes is amended to read:

609.22 **(3)** PRIMARY PROVIDER SELECTION. A ~~managed care~~ defined network plan that is not a preferred provider plan shall permit each enrollee to select his or her own primary provider from a list of participating primary care physicians and any other participating providers that are authorized by the ~~managed care~~ defined network plan to serve as primary providers. The list shall be updated on an ongoing basis and shall include a sufficient number of primary care physicians and any other participating providers authorized by the plan to serve as primary providers who are accepting new enrollees.

History: 1997 a. 237; 1999 a. 9.

→3741gmp

SECTION . 609.22 (4) (a) 1. of the statutes is amended to read:

609.22 **(4)** (a) 1. If a ~~managed care~~ defined network plan that is not a preferred provider plan requires a referral to a specialist for coverage of specialist services, the ~~managed care~~ defined network plan that is not a preferred provider plan shall establish a procedure by which an enrollee may apply for a standing referral to a specialist. The procedure must specify the criteria and conditions that must be met in order for an enrollee to obtain a standing referral.

History: 1997 a. 237; 1999 a. 9.

→3741gmt

SECTION . 609.22 (4) (a) 2. of the statutes is amended to read:

609.22 **(4)** (a) 2. A ~~managed care~~ defined network plan that is not a preferred provider plan may require the enrollee's primary provider to remain responsible for coordinating the care of an enrollee who receives a standing referral to a specialist. A ~~managed care~~ defined network plan that is not a preferred provider plan may restrict the specialist from making any secondary referrals without prior approval by the enrollee's primary provider. If an enrollee requests primary care services from a specialist to whom the enrollee has a standing referral, the specialist, in agreement with the enrollee and the enrollee's primary provider, may provide primary care

services to the enrollee in accordance with procedures established by the ~~managed care~~ defined network plan that is not a preferred provider plan.

History: 1997 a. 237; 1999 a. 9.

SECTION 3741 hmg. 609.22 (4) (a) 3. of the statutes is amended to read:

609.22 **(4)** (a) 3. A ~~managed care~~ defined network plan that is not a preferred provider plan must include information regarding referral procedures in policies or certificates provided to enrollees and must provide such information to an enrollee or prospective enrollee upon request.

History: 1997 a. 237; 1999 a. 9.

SECTION 3741 hmp. 609.22 (4m) (a) of the statutes is amended to read:

609.22 **(4m)** (a) A ~~managed care~~ defined network plan that provides coverage of obstetric or gynecologic services may not require a female enrollee of the ~~managed care~~ defined network plan to obtain a referral for covered obstetric or gynecologic benefits provided by a participating provider who is a physician licensed under ch. 448 and who specializes in obstetrics and gynecology, regardless of whether the participating provider is the enrollee's primary provider. Notwithstanding sub. (4), the ~~managed care~~ defined network plan may not require the enrollee to obtain a standing referral under the procedure established under sub. (4) (a) for covered obstetric or gynecologic benefits.

History: 1997 a. 237; 1999 a. 9.

SECTION 3741 hmt. 609.22 (4m) (b) (intro.) of the statutes is amended to read:

609.22 **(4m)** (b) (intro.) A ~~managed care~~ defined network plan under par. (a) may not do any of the following:

History: 1997 a. 237; 1999 a. 9.

SECTION 3741 ; mg. 609.22 (4m) (c) of the statutes is amended to read:

609.22 **(4m)** (c) A ~~managed care~~ defined network plan under par. (a) shall provide written notice of the requirement under par. (a) in every policy or group certificate issued by the ~~managed care~~ defined network plan.

History: 1997 a. 237; 1999 a. 9.

SECTION. 609.22 (5) of the statutes is amended to read:

609.22 **(5)** SECOND OPINIONS. A ~~managed care~~ defined network plan shall provide an enrollee with coverage for a 2nd opinion from another participating provider.

History: 1997 a. 237; 1999 a. 9.

SECTION. 609.22 (6) (intro.) of the statutes is amended to read:

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

History: 1997 a. 237; 1999 a. 9.

SECTION. 609.22 (7) of the statutes is amended to read:

609.22 **(7)** TELEPHONE ACCESS. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide telephone access for sufficient time during business and evening hours to ensure that enrollees have adequate access to routine health care services for which coverage is provided under the plan. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide 24–hour telephone access to the plan or to a participating provider for emergency care, or authorization for care, for which coverage is provided under the plan.

History: 1997 a. 237; 1999 a. 9.

SECTION. 609.22 (8) of the statutes is amended to read:

609.22 **(8)** ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed care~~ defined network plan shall develop an access plan to meet the needs, with respect to covered benefits, of its enrollees who are members of underserved populations. If a

significant number of enrollees of the plan customarily use languages other than English, the ~~managed care~~ defined network plan shall provide access to translation services fluent in those languages to the greatest extent possible.

History: 1997 a. 237; 1999 a. 9.

SECTION . 609.24 (1) (a) (intro.) of the statutes is amended to read:

609.24 **(1)** (a) (intro.) Subject to pars. (b) and (c) and except as provided in par. (d), a ~~managed care~~ defined network plan shall, with respect to covered benefits, provide coverage to an enrollee for the services of a provider, regardless of whether the provider is a participating provider at the time the services are provided, if the ~~managed care~~ defined network plan represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the enrollee at any of the following times:

History: 1997 a. 237.

SECTION . 609.24 (1) (b) (intro.) of the statutes is amended to read:

609.24 **(1)** (b) (intro.) Except as provided in par. (d), a ~~managed care~~ defined network plan shall provide the coverage required under par. (a) with respect to the services of a provider who is a primary care physician for the following period of time:

History: 1997 a. 237.

SECTION . 609.24 (1) (c) (intro.) of the statutes is amended to read:

609.24 **(1)** (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing a course of treatment with a participating provider who is not a primary care physician and whose participation with the plan terminates, the ~~managed care~~ defined network plan shall provide the coverage under par. (a) with respect to the services of the provider for the following period of time:

History: 1997 a. 237.

SECTION . 609.24 (1) (d) 1. of the statutes is amended to read:

609.24 (1) (d) 1. The provider no longer practices in the ~~managed care~~ defined network plan's geographic service area.

History: 1997 a. 237.

3741Lmg

SECTION 2. 609.24 (1) (d) 2. of the statutes is amended to read:

609.24 (1) (d) 2. The insurer issuing the ~~managed care~~ defined network plan terminates or terminated the provider's contract for misconduct on the part of the provider.

3741Lmp

History: 1997 a. 237.

SECTION 3. 609.24 (1) (e) 1. of the statutes is amended to read:

609.24 (1) (e) 1. An insurer issuing a ~~managed care~~ defined network plan shall include in its provider contracts provisions addressing reimbursement to providers for services rendered under this section.

3741Lmt

History: 1997 a. 237.

SECTION 4. 609.24 (1) (e) 2. of the statutes is amended to read:

609.24 (1) (e) 2. If a contract between a ~~managed care~~ defined network plan and a provider does not address reimbursement for services rendered under this section, the insurer shall reimburse the provider according to the most recent contracted rate.

3741mmb

History: 1997 a. 237.

SECTION 5. 609.24 (4) of the statutes is created to read:

609.24 (4) NOTICE OF PROVISIONS. A defined network plan shall notify all plan enrollees of the provisions under this section whenever a participating provider's participation with the plan terminates, or shall, by contract, require a participating provider to notify all plan enrollees of the provisions under this section if the participating provider's participation with the plan terminates.

3741mmd

SECTION 6. 609.30 (1) of the statutes is amended to read:

609.30 **(1)** PLAN MAY NOT CONTRACT. A ~~managed care~~ defined network plan may not contract with a participating provider to limit the provider's disclosure of information, to or on behalf of an enrollee, about the enrollee's medical condition or treatment options.

History: 1997 a. 237.

3741mmf

SECTION 5. 609.30 (2) of the statutes is amended to read:

609.30 **(2)** PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provider determines to be in the best interest of the enrollee. A ~~managed care~~ defined network plan may not penalize or terminate the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee.

History: 1997 a. 237.

3741mmh

SECTION 13. 609.32 (1) (intro.) of the statutes is amended to read:

609.32 **(1)** STANDARDS; OTHER THAN PERFERRED PROVIDER PLANS. (intro.) A ~~managed care~~ defined network plan that is not a preferred provider plan shall develop comprehensive quality assurance standards that are adequate to identify, evaluate, and remedy problems related to access to, and continuity and quality of, care. The standards shall include at least all of the following:

History: 1997 a. 237.

3741mmj

SECTION 19. 609.32 (1m) of the statutes is created to read:

609.32 **(1m)** PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A preferred provider plan shall develop procedures for remedying quality of care problems, including written procedures for taking appropriate corrective action.

3741mmn

SECTION 23. 609.32 (2) (a) of the statutes is amended to read:

609.32 **(2)** (a) A ~~managed care~~ defined network plan shall develop a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

History: 1997 a. 237.

SECTION. 609.32 (2) (b) (intro.) of the statutes is amended to read:

609.32 **(2)** (b) (intro.) A ~~managed care~~ defined network plan shall establish in writing a formal, ongoing process for reevaluating each participating provider within a specified number of years after the provider's initial acceptance for participation. The reevaluation shall include all of the following:

History: 1997 a. 237.

SECTION. 609.32 (2) (c) of the statutes is amended to read:

609.32 **(2)** (c) A ~~managed care~~ defined network plan may not require a participating provider to provide services that are outside the scope of his or her license or certificate.

History: 1997 a. 237.

SECTION. 609.34 of the statutes is renumbered 609.34 (1) and amended to read:

609.34 **(1)** A ~~managed care~~ defined network plan shall appoint a physician as medical director. The medical director shall be responsible for clinical protocols, quality assurance activities, and utilization management policies of the plan.

History: 1997 a. 237.

SECTION. 609.34 (2) of the statutes is created to read:

609.34 **(2)** Notwithstanding sub. (1), a preferred provider plan may contract for services related to clinical protocols and utilization management. A preferred provider plan or its designee is required to appoint a medical director only to the extent that the preferred provider plan or its designee assumes direct responsibility for clinical protocols and utilization management policies of the plan. The medical director, who shall be a physician, shall be responsible for such protocols and policies of the plan.

3741 nmz

SECTION 22. 609.36 (1) (a) (intro.) of the statutes is amended to read:

609.36 **(1)** (a) (intro.) A ~~managed care~~ defined network plan shall provide to the commissioner information related to all of the following:

3741 nmg

History: 1997 a. 237.

SECTION 23. 609.36 (2) of the statutes is amended to read:

609.36 **(2)** CONFIDENTIALITY. A ~~managed care~~ defined network plan shall establish written policies and procedures, consistent with ss. 51.30, 146.82, and 252.15, for the handling of medical records and enrollee communications to ensure confidentiality.

3741 nmp

History: 1997 a. 237.

SECTION 24. 609.38 of the statutes is amended to read:

609.38 Oversight. The office shall perform examinations of insurers that issue ~~managed care~~ defined network plans consistent with ss. 601.43 and 601.44. The commissioner shall by rule develop standards for ~~managed care~~ defined network plans for compliance with the requirements under this chapter.

3741 nmt

History: 1997 a. 237.

SECTION 25. 609.65 (1) (intro.) of the statutes is amended to read:

609.65 **(1)** (intro.) If an enrollee of a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is examined, evaluated, or treated for a nervous or mental disorder pursuant to an emergency

detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m) or (4r) or ch. 980, then, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) to (4) and 609.05 (3), the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall do all of the following:

3741omg

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237.

SECTION 3. 609.65 (1) (a) of the statutes is amended to read:

609.65 **(1)** (a) If the provider performing the examination, evaluation, or treatment has a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the provision of that service to the enrollee, make the service available to the enrollee in accordance with the terms of the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan and the provider agreement.

3741omp

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237.

SECTION 4. 609.65 (1) (b) (intro.) of the statutes is amended to read:

609.65 **(1)** (b) (intro.) If the provider performing the examination, evaluation or treatment does not have a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the provision of that service to the enrollee, reimburse the provider for the examination, evaluation, or treatment of the enrollee in an amount not to exceed the maximum reimbursement for the service under the medical assistance program under subch. IV of ch. 49, if any of the following applies:

3741omt

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237.

SECTION 5. 609.65 (1) (b) 1. of the statutes is amended to read:

609.65 **(1)** (b) 1. The service is provided pursuant to a commitment or a court order, except that reimbursement is not required under this subdivision if the limited service health organization, preferred provider plan, or ~~managed care~~ defined

network plan could have provided the service through a provider with whom it has a provider agreement. 3741 pmg

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237.

SECTION 22. 609.65 (1) (b) 2. of the statutes is amended to read:

609.65 **(1)** (b) 2. The service is provided pursuant to an emergency detention under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20 and the provider notifies the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan within 72 hours after the initial provision of the service. 3741 pmp

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237.

SECTION 23. 609.65 (2) of the statutes is amended to read:

609.65 **(2)** If after receiving notice under sub. (1) (b) 2. the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan arranges for services to be provided by a provider with whom it has a provider agreement, the limited service health organization, preferred provider plan, or ~~managed care~~ plan is not required to reimburse a provider under sub. (1) (b) 2. for any services provided after arrangements are made under this subsection.

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237. 3741 pmt

SECTION 24. 609.65 (3) of the statutes is amended to read:

609.65 **(3)** A limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is only required to make available, or make reimbursement for, an examination, evaluation, or treatment under sub. (1) to the extent that the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan would have made the medically necessary service available to the enrollee or reimbursed the provider for the service if any

referrals required under s. 609.05 (3) had been made and the service had been performed by a participating provider.

3741qmg

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237.

SECTION 27. 609.655 (1) (a) 1. of the statutes is amended to read:

609.655 **(1)** (a) 1. Is covered as a dependent child under the terms of a policy or certificate issued by a ~~managed care~~ defined network plan insurer.

3741qmp

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155.

SECTION 28. 609.655 (1) (a) 2. of the statutes is amended to read:

609.655 **(1)** (a) 2. Is enrolled in a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan.

3741qmt

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155.

SECTION 29. 609.655 (2) of the statutes is amended to read:

609.655 **(2)** If a policy or certificate issued by a ~~managed care~~ defined network plan insurer provides coverage of outpatient services provided to a dependent student, the policy or certificate shall provide coverage of outpatient services, to the extent and in the manner required under sub. (3), that are provided to the dependent student while he or she is attending a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) and 609.05 (3).

3741rmg

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155.

SECTION 30. 609.655 (3) (intro.) of the statutes is amended to read:

609.655 **(3)** (intro.) Except as provided in sub. (5), a ~~managed care~~ defined network plan shall provide coverage for all of the following services:

3741rmp

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155.

SECTION 31. 609.655 (3) (a) of the statutes is amended to read:

609.655 **(3)** (a) A clinical assessment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems, conducted by a

provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and who may be designated by the ~~managed care~~ defined network plan.

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155. → 3741smg

SECTION 21. 609.655 (3) (b) (intro.) of the statutes is amended to read:

609.655 **(3)** (b) (intro.) If outpatient services are recommended in the clinical assessment conducted under par. (a), the recommended outpatient services consisting of not more than 5 visits to an outpatient treatment facility or other provider that is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and that may be designated by the ~~managed care~~ defined network plan, except as follows:

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155. → 3741smp

SECTION 22. 609.655 (3) (b) 1. of the statutes is amended to read:

609.655 **(3)** (b) 1. Coverage is not required under this paragraph if the medical director of the ~~managed care~~ defined network plan determines that the nature of the treatment recommended in the clinical assessment will prohibit the dependent student from attending school on a regular basis.

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155. → 3741smt

SECTION 23. 609.655 (4) (a) of the statutes is amended to read:

609.655 **(4)** (a) Upon completion of the 5 visits for outpatient services covered under sub. (3) (b), the medical director of the ~~managed care~~ defined network plan and the clinician treating the dependent student shall review the dependent student's condition and determine whether it is appropriate to continue treatment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems in reasonably close proximity to the school in which the student is enrolled. The review is not required if the dependent student is no longer enrolled in the school

or if the coverage limits under the policy or certificate for treatment of nervous or mental disorders or alcoholism or other drug abuse problems have been exhausted.

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155.

SECTION 22. 609.655 (4) (b) of the statutes is amended to read:

609.655 **(4)** (b) Upon completion of the review under par. (a), the medical director of the ~~managed care~~ defined network plan shall determine whether the policy or certificate will provide coverage of any further treatment for the dependent student's nervous or mental disorder or alcoholism or other drug abuse problems that is provided by a provider located in reasonably close proximity to the school in which the student is enrolled. If the dependent student disputes the medical director's determination, the dependent student may submit a written grievance under the ~~managed care~~ defined network plan's internal grievance procedure established under s. 632.83.

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155.

SECTION 23. 609.655 (5) (a) of the statutes is amended to read:

609.655 **(5)** (a) A policy or certificate issued by a ~~managed care~~ defined network plan insurer is required to provide coverage for the services specified in sub. (3) only to the extent that the policy or certificate would have covered the service if it had been provided to the dependent student by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155.

SECTION 24. 609.655 (5) (b) of the statutes is amended to read:

609.655 **(5)** (b) Paragraph (a) does not permit a ~~managed care~~ defined network plan to reimburse a provider for less than the full cost of the services provided or an amount negotiated with the provider, solely because the reimbursement rate for the

service would have been less if provided by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

History: 1989 a. 121; 1993 a. 399; 1997 a. 237; 1999 a. 155.

SECTION 22. 609.70 of the statutes is amended to read:

609.70 Chiropractic coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.87 (3).

History: 1987 a. 27; 1997 a. 237.

SECTION 23. 609.75 of the statutes is amended to read:

609.75 Adopted children coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.896. Coverage of health care services obtained by adopted children and children placed for adoption may be subject to any requirements that the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained by other enrollees.

History: 1989 a. 336; 1997 a. 237.

SECTION 24. 609.77 of the statutes is amended to read:

609.77 Coverage of breast reconstruction. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (13).

History: 1997 a. 27, 237.

SECTION 25. 609.78 of the statutes is amended to read:

609.78 Coverage of treatment for the correction of temporomandibular disorders. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (11).

History: 1997 a. 27, 237.

3741vmp

SECTION 1. 609.79 of the statutes is amended to read:

609.79 Coverage of hospital and ambulatory surgery center charges and anesthetics for dental care. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (12).

3741vmt

History: 1997 a. 27, 237.

SECTION 2. 609.80 of the statutes is amended to read:

609.80 Coverage of mammograms. ~~Managed care~~ Defined network plans are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be subject to any requirements that the ~~managed care~~ defined network plan imposes under s. 609.05 (2) and (3) on the coverage of other health care services obtained by enrollees.

3741wmg

History: 1989 a. 129; 1997 a. 237.

SECTION 3. 609.81 of the statutes is amended to read:

609.81 Coverage related to HIV infection. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.93. ~~Managed care~~ Defined network plans are subject to s. 632.895 (9).

3741wmp

History: 1989 a. 201; 1989 a. 359 s. 389; 1997 a. 237.

SECTION 4. 609.82 of the statutes is amended to read:

609.82 Coverage without prior authorization for emergency medical condition treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.85.

3741wmt

History: 1997 a. 237.

SECTION 5. 609.83 of the statutes is amended to read:

609.83 Coverage of drugs and devices. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.853.

History: 1997 a. 237.

SECTION 3741xmg. 609.84 of the statutes is amended to read:

609.84 Experimental treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.855.

History: 1997 a. 237.

SECTION 3741xmp. 609.88 of the statutes is amended to read:

609.88 Coverage of immunizations. ~~Managed care~~ Defined network plans are subject to s. 632.895 (14).

History: 1999 a. 115.

SECTION 3741xmr. 609.89 of the statutes is amended to read:

609.89 Written reason for coverage denial. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.17.

History: 1999 a. 95.

Insert 21-14

4. Page 1181, line 12: after that line insert:

SECTION 3763f. 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. This paragraph applies to a ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 86, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672.

SECTION 3763g. 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 ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b).

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332. 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672.

(END)

Insert 21-14

(CS)(B) 3741xmt

Section #. 609.90 of the statutes is amended to read:

609.90 Restrictions related to domestic abuse. Limited service health organizations, preferred provider plans and ~~managed care~~ plans are subject to s. 631.95.»

History: 1999 a. 95.

defined network

(and adjust to 21-14)

Kahler, Pam

From: Lonergan, Sandra
Sent: Monday, June 25, 2001 2:05 PM
To: Kahler, Pam; Sweet, Richard; Smyrski, Rose
Subject: PPP language

Pam,
Here's the change:

609.18
Notwithstanding ss. 609.22 (2), (3), (4) and (7), 609.32 (1) and 609.34 (~~2~~1), a PPP that does not cover the same services whether performed by participating or nonparticipating providers is subject to ss. 609.22 (2), (3), (4) and (7), 609.32 (1) and 609.34 (1).

Please call if you have any questions.
Thanks,
Sandy

State of Wisconsin
2001 – 2002 LEGISLATURE

LRBb1515/2
PJK:cjs:rs

ARC:.....Hughes – AM66, Preferred provider plans

FOR 2001–03 BUDGET — NOT READY FOR INTRODUCTION

CAUCUS ASSEMBLY AMENDMENT

TO ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO 2001 SENATE BILL ~~55~~

TODAY (TUES 6/26)
BY 4:00 PM

At the locations indicated, amend the substitute amendment as follows:

1. Page 534, line 23: after that line insert:

"**SECTION 1398r.** 40.51 (12) of the statutes is amended to read:

40.51 **(12)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3e)~~ (1b), and every limited service health organization, as defined in s. 609.01 (3), that is offered by the state under sub. (6) shall comply with ch. 609.

SECTION 1398s. 40.51 (13) of the statutes is amended to read:

40.51 **(13)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3e)~~ (1b), and every limited service health organization, as defined in s. 609.01 (3),

that is offered by the group insurance board under sub. (7) shall comply with ch. 609.".

2. Page 1180, line 21: after that line insert:

"**SECTION 3741amc.** Chapter 609 (title) of the statutes is amended to read:

CHAPTER 609

~~MANAGED CARE~~ DEFINED NETWORK PLANS

SECTION 3741amg. 609.01 (1d) of the statutes is amended to read:

609.01 **(1d)** "Enrollee" means, with respect to a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization, a person who is entitled to receive health care services under the plan.

SECTION 3741amp. 609.01 (3c) of the statutes is renumbered 609.01 (1b) and amended to read:

609.01 **(1b)** "~~Managed care~~ Defined network plan" means a health benefit plan that requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with, or employed by the insurer offering the health benefit plan.

SECTION 3741amt. 609.01 (3m) of the statutes is amended to read:

609.01 **(3m)** "Participating" means, with respect to a physician or other provider, under contract with a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to provide health care services, items or supplies to enrollees of the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization.

SECTION 3741bmg. 609.01 (4) of the statutes is amended to read:

609.01 **(4)** "Preferred provider plan" means a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, 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 ~~participating in the plan~~.

SECTION 3741bmp. 609.01 (5) of the statutes is amended to read:

609.01 **(5)** "Primary provider" means a participating primary care physician, or other participating provider authorized by the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to serve as a primary provider, who coordinates and may provide ongoing care to an enrollee.

SECTION 3741bmt. 609.05 (1) of the statutes is amended to read:

609.05 **(1)** Except as provided in subs. (2) and (3), a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall permit its enrollees to choose freely among participating providers.

SECTION 3741cmg. 609.05 (2) of the statutes is amended to read:

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

SECTION 3741cmp. 609.05 (3) of the statutes is amended to read:

609.05 **(3)** Except as provided in ss. 609.22 (4m), 609.65, and 609.655, a limited service health organization, preferred provider plan, or ~~managed care~~ defined

network plan may require an enrollee to obtain a referral from the primary provider designated under sub. (2) to another participating provider prior to obtaining health care services from that participating provider.

SECTION 3741cmt. 609.17 of the statutes is amended to read:

609.17 Reports of disciplinary action. Every limited service health organization, preferred provider plan, and ~~managed care~~ defined network plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a participating provider who holds a license or certificate granted by the board or affiliated credentialing board.

SECTION 3741dmg. 609.20 (title) of the statutes is amended to read:

609.20 (title) **Rules for preferred provider and ~~managed care~~ defined network plans.**

SECTION 3741dmp. 609.20 (intro.) of the statutes is renumbered 609.20 (1m) (intro.) and amended to read:

609.20 **(1m)** (intro.) The commissioner shall promulgate rules relating to preferred provider plans and ~~managed care~~ defined network plans for all of the following purposes:

SECTION 3741dmt. 609.20 (1) of the statutes is renumbered 609.20 (1m) (a).

SECTION 3741emg. 609.20 (2) of the statutes is renumbered 609.20 (1m) (b).

SECTION 3741emp. 609.20 (2m) of the statutes is created to read:

609.20 **(2m)** Any rule promulgated under this chapter shall recognize the differences between preferred provider plans and other types of defined network plans, take into account the fact that preferred provider plans provide coverage for

the services of nonparticipating providers, and be appropriate to the type of plan to which the rule applies.

SECTION 3741emt. 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act 9, is renumbered 609.20 (1m) (c).

SECTION 3741fmg. 609.20 (4) of the statutes, as affected by 2001 Wisconsin Act 9, is renumbered 609.20 (1m) (d).

SECTION 3741fmp. 609.22 (1) of the statutes is amended to read:

609.22 **(1)** PROVIDERS. A ~~managed care~~ defined network plan shall include a sufficient number, and sufficient types, of qualified providers ~~[illegible]~~ to meet the anticipated needs of its enrollees, with respect to covered benefits and normal practices and standards in the geographic area.

SECTION 3741fmt. 609.22 (2) of the statutes is amended to read:

609.22 **(2)** ADEQUATE CHOICE. A ~~managed care~~ defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are accessible and qualified.

SECTION 3741gmg. 609.22 (3) of the statutes is amended to read:

609.22 **(3)** PRIMARY PROVIDER SELECTION. A ~~managed care~~ defined network plan that is not a preferred provider plan shall permit each enrollee to select his or her own primary provider from a list of participating primary care physicians and any other participating providers that are authorized by the ~~managed care~~ defined network plan to serve as primary providers. The list shall be updated on an ongoing basis and shall include a sufficient number of primary care physicians and any other participating providers authorized by the plan to serve as primary providers who are accepting new enrollees.

SECTION 3741gmp. 609.22 (4) (a) 1. of the statutes is amended to read:

609.22 **(4)** (a) 1. If a ~~managed care~~ defined network plan that is not a preferred provider plan requires a referral to a specialist for coverage of specialist services, the ~~managed care~~ defined network plan that is not a preferred provider plan shall establish a procedure by which an enrollee may apply for a standing referral to a specialist. The procedure must specify the criteria and conditions that must be met in order for an enrollee to obtain a standing referral.

SECTION 3741gmt. 609.22 (4) (a) 2. of the statutes is amended to read:

609.22 **(4)** (a) 2. A ~~managed care~~ defined network plan that is not a preferred provider plan may require the enrollee's primary provider to remain responsible for coordinating the care of an enrollee who receives a standing referral to a specialist. A ~~managed care~~ defined network plan that is not a preferred provider plan may restrict the specialist from making any secondary referrals without prior approval by the enrollee's primary provider. If an enrollee requests primary care services from a specialist to whom the enrollee has a standing referral, the specialist, in agreement with the enrollee and the enrollee's primary provider, may provide primary care services to the enrollee in accordance with procedures established by the ~~managed care~~ defined network plan that is not a preferred provider plan.

SECTION 3741hmg. 609.22 (4) (a) 3. of the statutes is amended to read:

609.22 **(4)** (a) 3. A ~~managed care~~ defined network plan that is not a preferred provider plan must include information regarding referral procedures in policies or certificates provided to enrollees and must provide such information to an enrollee or prospective enrollee upon request.

SECTION 3741hmp. 609.22 (4m) (a) of the statutes is amended to read:

609.22 **(4m)** (a) A ~~managed care~~ defined network plan that provides coverage of obstetric or gynecologic services may not require a female enrollee of the ~~managed care~~ defined network plan to obtain a referral for covered obstetric or gynecologic benefits provided by a participating provider who is a physician licensed under ch. 448 and who specializes in obstetrics and gynecology, regardless of whether the participating provider is the enrollee's primary provider. Notwithstanding sub. (4), the ~~managed care~~ defined network plan may not require the enrollee to obtain a standing referral under the procedure established under sub. (4) (a) for covered obstetric or gynecologic benefits.

SECTION 3741hmt. 609.22 (4m) (b) (intro.) of the statutes is amended to read:

609.22 **(4m)** (b) (intro.) A ~~managed care~~ defined network plan under par. (a) may not do any of the following:

SECTION 3741img. 609.22 (4m) (c) of the statutes is amended to read:

609.22 **(4m)** (c) A ~~managed care~~ defined network plan under par. (a) shall provide written notice of the requirement under par. (a) in every policy or group certificate issued by the ~~managed care~~ defined network plan.

SECTION 3741imp. 609.22 (5) of the statutes is amended to read:

609.22 **(5)** SECOND OPINIONS. A ~~managed care~~ defined network plan shall provide an enrollee with coverage for a 2nd opinion from another participating provider.

SECTION 3741imt. 609.22 (6) (intro.) of the statutes is amended to read:

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

SECTION 3741jmg. 609.22 (7) of the statutes is amended to read:

609.22 **(7)** TELEPHONE ACCESS. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide telephone access for sufficient time during business and evening hours to ensure that enrollees have adequate access to routine health care services for which coverage is provided under the plan. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide 24–hour telephone access to the plan or to a participating provider for emergency care, or authorization for care, for which coverage is provided under the plan.

SECTION 3741jmp. 609.22 (8) of the statutes is amended to read:

609.22 **(8)** ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed care~~ defined network plan shall develop an access plan to meet the needs, with respect to covered benefits, of its enrollees who are members of underserved populations. If a significant number of enrollees of the plan customarily use languages other than English, the ~~managed care~~ defined network plan shall provide access to translation services fluent in those languages to the greatest extent possible.

SECTION 3741jmt. 609.24 (1) (a) (intro.) of the statutes is amended to read:

609.24 **(1)** (a) (intro.) Subject to pars. (b) and (c) and except as provided in par. (d), a ~~managed care~~ defined network plan shall, with respect to covered benefits, provide coverage to an enrollee for the services of a provider, regardless of whether the provider is a participating provider at the time the services are provided, if the ~~managed care~~ defined network plan represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the enrollee at any of the following times:

SECTION 3741kmg. 609.24 (1) (b) (intro.) of the statutes is amended to read:

609.24 **(1)** (b) (intro.) Except as provided in par. (d), a ~~managed care~~ defined network plan shall provide the coverage required under par. (a) with respect to the services of a provider who is a primary care physician for the following period of time:

SECTION 3741kmp. 609.24 (1) (c) (intro.) of the statutes is amended to read:

609.24 **(1)** (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing a course of treatment with a participating provider who is not a primary care physician and whose participation with the plan terminates, the ~~managed care~~ defined network plan shall provide the coverage under par. (a) with respect to the services of the provider for the following period of time:

SECTION 3741kmt. 609.24 (1) (d) 1. of the statutes is amended to read:

609.24 **(1)** (d) 1. The provider no longer practices in the ~~managed care~~ defined network plan's geographic service area.

SECTION 3741Lmg. 609.24 (1) (d) 2. of the statutes is amended to read:

609.24 **(1)** (d) 2. The insurer issuing the ~~managed care~~ defined network plan terminates or terminated the provider's contract for misconduct on the part of the provider.

SECTION 3471Lmp. 609.24 (1) (e) 1. of the statutes is amended to read:

609.24 **(1)** (e) 1. An insurer issuing a ~~managed care~~ defined network plan shall include in its provider contracts provisions addressing reimbursement to providers for services rendered under this section.

SECTION 3741Lmt. 609.24 (1) (e) 2. of the statutes is amended to read:

609.24 **(1)** (e) 2. If a contract between a ~~managed care~~ defined network plan and a provider does not address reimbursement for services rendered under this section, the insurer shall reimburse the provider according to the most recent contracted rate.

SECTION 3741mmb. 609.24 (4) of the statutes is created to read:

609.24 **(4)** NOTICE OF PROVISIONS. A defined network plan shall notify all plan enrollees of the provisions under this section whenever a participating provider's participation with the plan terminates, or shall, by contract, require a participating provider to notify all plan enrollees of the provisions under this section if the participating provider's participation with the plan terminates.

SECTION 3741mmd. 609.30 (1) of the statutes is amended to read:

609.30 **(1)** PLAN MAY NOT CONTRACT. A ~~managed care~~ defined network plan may not contract with a participating provider to limit the provider's disclosure of information, to or on behalf of an enrollee, about the enrollee's medical condition or treatment options.

SECTION 3741mmf. 609.30 (2) of the statutes is amended to read:

609.30 **(2)** PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provider determines to be in the best interest of the enrollee. A ~~managed care~~ defined network plan may not penalize or terminate the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee.

SECTION 3741mmh. 609.32 (1) (intro.) of the statutes is amended to read:

609.32 **(1)** STANDARDS; OTHER THAN PREFERRED PROVIDER PLANS. (intro.) A ~~managed care~~ defined network plan that is not a preferred provider plan shall develop comprehensive quality assurance standards that are adequate to identify, evaluate, and remedy problems related to access to, and continuity and quality of, care. The standards shall include at least all of the following:

remedial action to address

SECTION 3741mmj. 609.32 (1m) of the statutes is created to read:

609.32 **(1m)** PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A preferred provider plan shall develop a procedure for ~~remedying~~ quality of care problems, including written procedures for taking appropriate corrective action.

SECTION 3741mmn. 609.32 (2) (a) of the statutes is amended to read:

609.32 **(2)** (a) A ~~managed care~~ defined network plan shall develop a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

SECTION 3741mmp. 609.32 (2) (b) (intro.) of the statutes is amended to read:

609.32 **(2)** (b) (intro.) A ~~managed care~~ defined network plan shall establish in writing a formal, ongoing process for reevaluating each participating provider within a specified number of years after the provider's initial acceptance for participation. The reevaluation shall include all of the following:

SECTION 3741mmr. 609.32 (2) (c) of the statutes is amended to read:

609.32 **(2)** (c) A ~~managed care~~ defined network plan may not require a participating provider to provide services that are outside the scope of his or her license or certificate.

SECTION 3741mmt. 609.34 of the statutes is renumbered 609.34 (1) and amended to read:

609.34 **(1)** A ~~managed care~~ defined network plan shall appoint a physician as medical director. The medical director shall be responsible for clinical protocols, quality assurance activities, and utilization management policies of the plan.

SECTION 3741mmx. 609.34 (2) of the statutes is created to read:

609.34 **(2)** Notwithstanding sub. (1), a preferred provider plan may contract for services related to clinical protocols and utilization management. A preferred provider plan or its designee is required to appoint a medical director only to the extent that the preferred provider plan or its designee assumes direct responsibility for clinical protocols and utilization management policies of the plan. The medical director, who shall be a physician, shall be responsible for such protocols and policies of the plan.

SECTION 3741mmz. 609.36 (1) (a) (intro.) of the statutes is amended to read:

609.36 **(1)** (a) (intro.) A ~~managed care~~ defined network plan shall provide to the commissioner information related to all of the following:

SECTION 3741nmg. 609.36 (2) of the statutes is amended to read:

609.36 **(2)** CONFIDENTIALITY. A ~~managed care~~ defined network plan shall establish written policies and procedures, consistent with ss. 51.30, 146.82, and 252.15, for the handling of medical records and enrollee communications to ensure confidentiality.

SECTION 3741nmp. 609.38 of the statutes is amended to read:

609.38 Oversight. The office shall perform examinations of insurers that issue ~~managed care~~ defined network plans consistent with ss. 601.43 and 601.44. The commissioner shall by rule develop standards for ~~managed care~~ defined network plans for compliance with the requirements under this chapter.

SECTION 3741nmt. 609.65 (1) (intro.) of the statutes is amended to read:

609.65 **(1)** (intro.) If an enrollee of a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is examined, evaluated, or treated for a nervous or mental disorder pursuant to an emergency detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m) or (4r) or ch. 980, then, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) to (4) and 609.05 (3), the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall do all of the following:

SECTION 3741omg. 609.65 (1) (a) of the statutes is amended to read:

609.65 **(1)** (a) If the provider performing the examination, evaluation, or treatment has a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the provision of that service to the enrollee, make the service available to the enrollee in accordance with the terms of the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan and the provider agreement.

SECTION 3741omp. 609.65 (1) (b) (intro.) of the statutes is amended to read:

609.65 **(1)** (b) (intro.) If the provider performing the examination, evaluation or treatment does not have a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the provision of that service to the enrollee, reimburse the provider for the examination, evaluation, or treatment of the enrollee in an amount not to exceed the maximum reimbursement for the service under the medical assistance program under subch. IV of ch. 49, if any of the following applies:

SECTION 3741omt. 609.65 (1) (b) 1. of the statutes is amended to read:

609.65 **(1)** (b) 1. The service is provided pursuant to a commitment or a court order, except that reimbursement is not required under this subdivision if the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan could have provided the service through a provider with whom it has a provider agreement.

SECTION 3741pmg. 609.65 (1) (b) 2. of the statutes is amended to read:

609.65 **(1)** (b) 2. The service is provided pursuant to an emergency detention under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20 and the provider notifies the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan within 72 hours after the initial provision of the service.

SECTION 3741pmp. 609.65 (2) of the statutes is amended to read:

609.65 **(2)** If after receiving notice under sub. (1) (b) 2. the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan arranges for services to be provided by a provider with whom it has a provider agreement, the limited service health organization, preferred provider plan, or ~~managed care~~ plan is not required to reimburse a provider under sub. (1) (b) 2. for any services provided after arrangements are made under this subsection.

SECTION 3741pmt. 609.65 (3) of the statutes is amended to read:

609.65 **(3)** A limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is only required to make available, or make reimbursement for, an examination, evaluation, or treatment under sub. (1) to the extent that the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan would have made the medically necessary service available to the enrollee or reimbursed the provider for the service if any

referrals required under s. 609.05 (3) had been made and the service had been performed by a participating provider.

SECTION 3741qmg. 609.655 (1) (a) 1. of the statutes is amended to read:

609.655 **(1)** (a) 1. Is covered as a dependent child under the terms of a policy or certificate issued by a ~~managed care~~ defined network plan insurer.

SECTION 3741qmp. 609.655 (1) (a) 2. of the statutes is amended to read:

609.655 **(1)** (a) 2. Is enrolled in a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741qmt. 609.655 (2) of the statutes is amended to read:

609.655 **(2)** If a policy or certificate issued by a ~~managed care~~ defined network plan insurer provides coverage of outpatient services provided to a dependent student, the policy or certificate shall provide coverage of outpatient services, to the extent and in the manner required under sub. (3), that are provided to the dependent student while he or she is attending a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) and 609.05 (3).

SECTION 3741rmg. 609.655 (3) (intro.) of the statutes is amended to read:

609.655 **(3)** (intro.) Except as provided in sub. (5), a ~~managed care~~ defined network plan shall provide coverage for all of the following services:

SECTION 3741rmp. 609.655 (3) (a) of the statutes is amended to read:

609.655 **(3)** (a) A clinical assessment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems, conducted by a provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in

reasonably close proximity to the school in which the dependent student is enrolled and who may be designated by the ~~managed care~~ defined network plan.

SECTION 3741smg. 609.655 (3) (b) (intro.) of the statutes is amended to read:

609.655 **(3)** (b) (intro.) If outpatient services are recommended in the clinical assessment conducted under par. (a), the recommended outpatient services consisting of not more than 5 visits to an outpatient treatment facility or other provider that is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and that may be designated by the ~~managed care~~ defined network plan, except as follows:

SECTION 3741smp. 609.655 (3) (b) 1. of the statutes is amended to read:

609.655 **(3)** (b) 1. Coverage is not required under this paragraph if the medical director of the ~~managed care~~ defined network plan determines that the nature of the treatment recommended in the clinical assessment will prohibit the dependent student from attending school on a regular basis.

SECTION 3741smt. 609.655 (4) (a) of the statutes is amended to read:

609.655 **(4)** (a) Upon completion of the 5 visits for outpatient services covered under sub. (3) (b), the medical director of the ~~managed care~~ defined network plan and the clinician treating the dependent student shall review the dependent student's condition and determine whether it is appropriate to continue treatment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems in reasonably close proximity to the school in which the student is enrolled. The review is not required if the dependent student is no longer enrolled in the school or if the coverage limits under the policy or certificate for treatment of nervous or mental disorders or alcoholism or other drug abuse problems have been exhausted.

SECTION 3741tmg. 609.655 (4) (b) of the statutes is amended to read:

609.655 **(4)** (b) Upon completion of the review under par. (a), the medical director of the ~~managed care~~ defined network plan shall determine whether the policy or certificate will provide coverage of any further treatment for the dependent student's nervous or mental disorder or alcoholism or other drug abuse problems that is provided by a provider located in reasonably close proximity to the school in which the student is enrolled. If the dependent student disputes the medical director's determination, the dependent student may submit a written grievance under the ~~managed care~~ defined network plan's internal grievance procedure established under s. 632.83.

SECTION 3741tmp. 609.655 (5) (a) of the statutes is amended to read:

609.655 **(5)** (a) A policy or certificate issued by a ~~managed care~~ defined network plan insurer is required to provide coverage for the services specified in sub. (3) only to the extent that the policy or certificate would have covered the service if it had been provided to the dependent student by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741tmt. 609.655 (5) (b) of the statutes is amended to read:

609.655 **(5)** (b) Paragraph (a) does not permit a ~~managed care~~ defined network plan to reimburse a provider for less than the full cost of the services provided or an amount negotiated with the provider, solely because the reimbursement rate for the service would have been less if provided by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741umg. 609.70 of the statutes is amended to read:

609.70 Chiropractic coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.87 (3).

SECTION 3741ump. 609.75 of the statutes is amended to read:

609.75 Adopted children coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.896. Coverage of health care services obtained by adopted children and children placed for adoption may be subject to any requirements that the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained by other enrollees.

SECTION 3741umt. 609.77 of the statutes is amended to read:

609.77 Coverage of breast reconstruction. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (13).

SECTION 3741vmg. 609.78 of the statutes is amended to read:

609.78 Coverage of treatment for the correction of temporomandibular disorders. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (11).

SECTION 3741vmp. 609.79 of the statutes is amended to read:

609.79 Coverage of hospital and ambulatory surgery center charges and anesthetics for dental care. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (12).

SECTION 3741vmt. 609.80 of the statutes is amended to read:

609.80 Coverage of mammograms. ~~Managed care~~ Defined network plans are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be

subject to any requirements that the ~~managed care~~ defined network plan imposes under s. 609.05 (2) and (3) on the coverage of other health care services obtained by enrollees.

SECTION 3741wmg. 609.81 of the statutes is amended to read:

609.81 Coverage related to HIV infection. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.93. ~~Managed care~~ Defined network plans are subject to s. 632.895 (9).

SECTION 3741wmp. 609.82 of the statutes is amended to read:

609.82 Coverage without prior authorization for emergency medical condition treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.85.

SECTION 3741wmt. 609.83 of the statutes is amended to read:

609.83 Coverage of drugs and devices. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.853.

SECTION 3741xmg. 609.84 of the statutes is amended to read:

609.84 Experimental treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.855.

SECTION 3741xmp. 609.88 of the statutes is amended to read:

609.88 Coverage of immunizations. ~~Managed care~~ Defined network plans are subject to s. 632.895 (14).

SECTION 3741xmr. 609.89 of the statutes is amended to read:

609.89 Written reason for coverage denial. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.17.

SECTION 3741xmt. 609.90 of the statutes is amended to read:

609.90 Restrictions related to domestic abuse. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.95.".

3. Page 1181, line 12: after that line insert:

"**SECTION 3763f.** 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. This paragraph applies to a ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

SECTION 3763g. 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 ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b).".

(END)

INSERT 12–11

SECTION 3741mmy. 609.35 of the statutes is created to read:

609.35 Applicability of requirements to preferred provider plans. Notwithstanding ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1).

(END OF INSERT 12–11)

Kahler, Pam

From: Kahler, Pam
Sent: Wednesday, June 27, 2001 10:20 AM
To: Lonergan, Sandra
Subject: RE: LRB Draft: 01b1515/2 Preferred provider plans

Sandy:

1. First, the PPP separate listing issue. "Managed care plan," (and now defined network plan) is defined as a health benefit plan that has certain features. "Health benefit plan" is defined in such a way that plans that provide a limited range of services, such as limited service health organizations and some PPP's, are not included. Thus, mandates that apply to those plans that offer a limited range of services must be made specifically applicable to LSHO's and PPP's. If those mandates only applied to defined network plans, they would not apply to LSHO's or PPP's that offer limited services.

2. I agree that the cross-reference should be changed, but a better way to make the change would be to make s. 609.34 consistent with the other sections by having sub. (1) apply to a defined network plan *that is not a PPP* and sub. (2) apply to a PPP. That way it is also less confusing (notwithstanding the notwithstanding). Okay?

Pam

-----Original Message-----
From: Lonergan, Sandra
Sent: Tuesday, June 26, 2001 6:03 PM
To: Kahler, Pam
Cc: Smyrski, Rose; Sweet, Richard
Subject: FW: LRB Draft: 01b1515/2 Preferred provider plans

Hi lovely Pam Kahler,
One change please -- on page 12, line 14 the 609.34 (1) should be 609.34 (2). As Dick says, "We have to notwithstand the notwithstanding clause."

Also, please tell me again why the PPPs need to be listed specifically in the mandates sections. I'm afraid I wasn't able to explain it very well to the HMOs.

Thanks,
Sandy

-----Original Message-----
From: Hughes, Carolyn
Sent: Tuesday, June 26, 2001 3:38 PM
To: Smyrski, Rose; Lonergan, Sandra
Subject: FW: LRB Draft: 01b1515/2 Preferred provider plans

let me know if this is right...

-----Original Message-----
From: Frantzen, Jean
Sent: Tuesday, June 26, 2001 3:21 PM
To: Hughes, Carolyn
Cc: Legislative Fiscal Bureau; Hanaman, Cathlene; Haugen, Caroline
Subject: LRB Draft: 01b1515/2 Preferred provider plans

Following is the PDF version of draft 01b1515/2.

<< File: 01b1515/2 >>

State of Wisconsin
2001 – 2002 LEGISLATURE

LRBb1515/3
PJK:cjs:jf
pmis new

ARC:.....Hughes – AM66, Preferred provider plans

FOR 2001–03 BUDGET — NOT READY FOR INTRODUCTION

CAUCUS ASSEMBLY AMENDMENT
TO ASSEMBLY SUBSTITUTE AMENDMENT 1,
TO 2001 SENATE BILL 55

p. 12

At the locations indicated, amend the substitute amendment as follows:

1. Page 534, line 23: after that line insert:

"**SECTION 1398r.** 40.51 (12) of the statutes is amended to read:

40.51 **(12)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), and every limited service health organization, as defined in s. 609.01 (3), that is offered by the state under sub. (6) shall comply with ch. 609.

SECTION 1398s. 40.51 (13) of the statutes is amended to read:

40.51 **(13)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), and every limited service health organization, as defined in s. 609.01 (3),

that is offered by the group insurance board under sub. (7) shall comply with ch. 609.".

2. Page 1180, line 21: after that line insert:

"**SECTION 3741amc.** Chapter 609 (title) of the statutes is amended to read:

CHAPTER 609

~~MANAGED CARE~~ DEFINED NETWORK PLANS

SECTION 3741amg. 609.01 (1d) of the statutes is amended to read:

609.01 **(1d)** "Enrollee" means, with respect to a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization, a person who is entitled to receive health care services under the plan.

SECTION 3741amp. 609.01 (3c) of the statutes is renumbered 609.01 (1b) and amended to read:

609.01 **(1b)** "~~Managed care~~ Defined network plan" means a health benefit plan that requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with, or employed by the insurer offering the health benefit plan.

SECTION 3741amt. 609.01 (3m) of the statutes is amended to read:

609.01 **(3m)** "Participating" means, with respect to a physician or other provider, under contract with a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to provide health care services, items or supplies to enrollees of the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization.

SECTION 3741bmg. 609.01 (4) of the statutes is amended to read:

609.01 **(4)** "Preferred provider plan" means a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, 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 ~~participating in the plan~~.

SECTION 3741bmp. 609.01 (5) of the statutes is amended to read:

609.01 **(5)** "Primary provider" means a participating primary care physician, or other participating provider authorized by the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to serve as a primary provider, who coordinates and may provide ongoing care to an enrollee.

SECTION 3741bmt. 609.05 (1) of the statutes is amended to read:

609.05 **(1)** Except as provided in subs. (2) and (3), a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall permit its enrollees to choose freely among participating providers.

SECTION 3741cmg. 609.05 (2) of the statutes is amended to read:

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

SECTION 3741cmp. 609.05 (3) of the statutes is amended to read:

609.05 **(3)** Except as provided in ss. 609.22 (4m), 609.65, and 609.655, a limited service health organization, preferred provider plan, or ~~managed care~~ defined

network plan may require an enrollee to obtain a referral from the primary provider designated under sub. (2) to another participating provider prior to obtaining health care services from that participating provider.

SECTION 3741cmt. 609.17 of the statutes is amended to read:

609.17 Reports of disciplinary action. Every limited service health organization, preferred provider plan, and ~~managed care~~ defined network plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a participating provider who holds a license or certificate granted by the board or affiliated credentialing board.

SECTION 3741dmg. 609.20 (title) of the statutes is amended to read:

609.20 (title) **Rules for preferred provider and ~~managed care~~ defined network plans.**

SECTION 3741dmp. 609.20 (intro.) of the statutes is renumbered 609.20 (1m) (intro.) and amended to read:

609.20 **(1m)** (intro.) The commissioner shall promulgate rules relating to preferred provider plans and ~~managed care~~ defined network plans for all of the following purposes:

SECTION 3741dmt. 609.20 (1) of the statutes is renumbered 609.20 (1m) (a).

SECTION 3741emg. 609.20 (2) of the statutes is renumbered 609.20 (1m) (b).

SECTION 3741emp. 609.20 (2m) of the statutes is created to read:

609.20 **(2m)** Any rule promulgated under this chapter shall recognize the differences between preferred provider plans and other types of defined network plans, take into account the fact that preferred provider plans provide coverage for

the services of nonparticipating providers, and be appropriate to the type of plan to which the rule applies.

SECTION 3741emt. 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act 9, is renumbered 609.20 (1m) (c).

SECTION 3741fmg. 609.20 (4) of the statutes, as affected by 2001 Wisconsin Act 9, is renumbered 609.20 (1m) (d).

SECTION 3741fmp. 609.22 (1) of the statutes is amended to read:

609.22 **(1)** PROVIDERS. A ~~managed care~~ defined network plan shall include a sufficient number, and sufficient types, of qualified providers to meet the anticipated needs of its enrollees, with respect to covered benefits, as appropriate to the type of plan and consistent with normal practices and standards in the geographic area.

SECTION 3741fmt. 609.22 (2) of the statutes is amended to read:

609.22 **(2)** ADEQUATE CHOICE. A ~~managed care~~ defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are accessible and qualified.

SECTION 3741gmg. 609.22 (3) of the statutes is amended to read:

609.22 **(3)** PRIMARY PROVIDER SELECTION. A ~~managed care~~ defined network plan that is not a preferred provider plan shall permit each enrollee to select his or her own primary provider from a list of participating primary care physicians and any other participating providers that are authorized by the ~~managed care~~ defined network plan to serve as primary providers. The list shall be updated on an ongoing basis and shall include a sufficient number of primary care physicians and any other participating providers authorized by the plan to serve as primary providers who are accepting new enrollees.

SECTION 3741gmp. 609.22 (4) (a) 1. of the statutes is amended to read:

609.22 **(4)** (a) 1. If a ~~managed care~~ defined network plan that is not a preferred provider plan requires a referral to a specialist for coverage of specialist services, the ~~managed care~~ defined network plan that is not a preferred provider plan shall establish a procedure by which an enrollee may apply for a standing referral to a specialist. The procedure must specify the criteria and conditions that must be met in order for an enrollee to obtain a standing referral.

SECTION 3741gmt. 609.22 (4) (a) 2. of the statutes is amended to read:

609.22 **(4)** (a) 2. A ~~managed care~~ defined network plan that is not a preferred provider plan may require the enrollee's primary provider to remain responsible for coordinating the care of an enrollee who receives a standing referral to a specialist. A ~~managed care~~ defined network plan that is not a preferred provider plan may restrict the specialist from making any secondary referrals without prior approval by the enrollee's primary provider. If an enrollee requests primary care services from a specialist to whom the enrollee has a standing referral, the specialist, in agreement with the enrollee and the enrollee's primary provider, may provide primary care services to the enrollee in accordance with procedures established by the ~~managed care~~ defined network plan that is not a preferred provider plan.

SECTION 3741hmg. 609.22 (4) (a) 3. of the statutes is amended to read:

609.22 **(4)** (a) 3. A ~~managed care~~ defined network plan that is not a preferred provider plan must include information regarding referral procedures in policies or certificates provided to enrollees and must provide such information to an enrollee or prospective enrollee upon request.

SECTION 3741hmp. 609.22 (4m) (a) of the statutes is amended to read:

609.22 **(4m)** (a) A ~~managed care~~ defined network plan that provides coverage of obstetric or gynecologic services may not require a female enrollee of the ~~managed care~~ defined network plan to obtain a referral for covered obstetric or gynecologic benefits provided by a participating provider who is a physician licensed under ch. 448 and who specializes in obstetrics and gynecology, regardless of whether the participating provider is the enrollee's primary provider. Notwithstanding sub. (4), the ~~managed care~~ defined network plan may not require the enrollee to obtain a standing referral under the procedure established under sub. (4) (a) for covered obstetric or gynecologic benefits.

SECTION 3741hmt. 609.22 (4m) (b) (intro.) of the statutes is amended to read:

609.22 **(4m)** (b) (intro.) A ~~managed care~~ defined network plan under par. (a) may not do any of the following:

SECTION 3741img. 609.22 (4m) (c) of the statutes is amended to read:

609.22 **(4m)** (c) A ~~managed care~~ defined network plan under par. (a) shall provide written notice of the requirement under par. (a) in every policy or group certificate issued by the ~~managed care~~ defined network plan.

SECTION 3741imp. 609.22 (5) of the statutes is amended to read:

609.22 **(5)** SECOND OPINIONS. A ~~managed care~~ defined network plan shall provide an enrollee with coverage for a 2nd opinion from another participating provider.

SECTION 3741imt. 609.22 (6) (intro.) of the statutes is amended to read:

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

SECTION 3741jmg. 609.22 (7) of the statutes is amended to read:

609.22 **(7)** TELEPHONE ACCESS. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide telephone access for sufficient time during business and evening hours to ensure that enrollees have adequate access to routine health care services for which coverage is provided under the plan. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide 24–hour telephone access to the plan or to a participating provider for emergency care, or authorization for care, for which coverage is provided under the plan.

SECTION 3741jmp. 609.22 (8) of the statutes is amended to read:

609.22 **(8)** ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed care~~ defined network plan shall develop an access plan to meet the needs, with respect to covered benefits, of its enrollees who are members of underserved populations. If a significant number of enrollees of the plan customarily use languages other than English, the ~~managed care~~ defined network plan shall provide access to translation services fluent in those languages to the greatest extent possible.

SECTION 3741jmt. 609.24 (1) (a) (intro.) of the statutes is amended to read:

609.24 **(1)** (a) (intro.) Subject to pars. (b) and (c) and except as provided in par. (d), a ~~managed care~~ defined network plan shall, with respect to covered benefits, provide coverage to an enrollee for the services of a provider, regardless of whether the provider is a participating provider at the time the services are provided, if the ~~managed care~~ defined network plan represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the enrollee at any of the following times:

SECTION 3741kmg. 609.24 (1) (b) (intro.) of the statutes is amended to read:

609.24 **(1)** (b) (intro.) Except as provided in par. (d), a ~~managed care~~ defined network plan shall provide the coverage required under par. (a) with respect to the services of a provider who is a primary care physician for the following period of time:

SECTION 3741kmp. 609.24 (1) (c) (intro.) of the statutes is amended to read:

609.24 **(1)** (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing a course of treatment with a participating provider who is not a primary care physician and whose participation with the plan terminates, the ~~managed care~~ defined network plan shall provide the coverage under par. (a) with respect to the services of the provider for the following period of time:

SECTION 3741kmt. 609.24 (1) (d) 1. of the statutes is amended to read:

609.24 **(1)** (d) 1. The provider no longer practices in the ~~managed care~~ defined network plan's geographic service area.

SECTION 3741Lmg. 609.24 (1) (d) 2. of the statutes is amended to read:

609.24 **(1)** (d) 2. The insurer issuing the ~~managed care~~ defined network plan terminates or terminated the provider's contract for misconduct on the part of the provider.

SECTION 3471Lmp. 609.24 (1) (e) 1. of the statutes is amended to read:

609.24 **(1)** (e) 1. An insurer issuing a ~~managed care~~ defined network plan shall include in its provider contracts provisions addressing reimbursement to providers for services rendered under this section.

SECTION 3741Lmt. 609.24 (1) (e) 2. of the statutes is amended to read:

609.24 **(1)** (e) 2. If a contract between a managed care defined network plan and a provider does not address reimbursement for services rendered under this section, the insurer shall reimburse the provider according to the most recent contracted rate.

SECTION 3741mmb. 609.24 (4) of the statutes is created to read:

609.24 **(4)** NOTICE OF PROVISIONS. A defined network plan shall notify all plan enrollees of the provisions under this section whenever a participating provider's participation with the plan terminates, or shall, by contract, require a participating provider to notify all plan enrollees of the provisions under this section if the participating provider's participation with the plan terminates.

SECTION 3741mmd. 609.30 (1) of the statutes is amended to read:

609.30 **(1)** PLAN MAY NOT CONTRACT. A ~~managed care~~ defined network plan may not contract with a participating provider to limit the provider's disclosure of information, to or on behalf of an enrollee, about the enrollee's medical condition or treatment options.

SECTION 3741mmf. 609.30 (2) of the statutes is amended to read:

609.30 **(2)** PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provider determines to be in the best interest of the enrollee. A ~~managed care~~ defined network plan may not penalize or terminate the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee.

SECTION 3741mmh. 609.32 (1) (intro.) of the statutes is amended to read:

609.32 **(1)** STANDARDS; OTHER THAN PREFERRED PROVIDER PLANS. (intro.) A ~~managed care~~ defined network plan that is not a preferred provider plan shall develop comprehensive quality assurance standards that are adequate to identify, evaluate, and remedy problems related to access to, and continuity and quality of, care. The standards shall include at least all of the following:

SECTION 3741mmj. 609.32 (1m) of the statutes is created to read:

609.32 **(1m)** PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A preferred provider plan shall develop a procedure for remedial action to address quality problems, including written procedures for taking appropriate corrective action.

SECTION 3741mmn. 609.32 (2) (a) of the statutes is amended to read:

609.32 **(2)** (a) A ~~managed care~~ defined network plan shall develop a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

SECTION 3741mmp. 609.32 (2) (b) (intro.) of the statutes is amended to read:

609.32 **(2)** (b) (intro.) A ~~managed care~~ defined network plan shall establish in writing a formal, ongoing process for reevaluating each participating provider within a specified number of years after the provider's initial acceptance for participation. The reevaluation shall include all of the following:

SECTION 3741mmr. 609.32 (2) (c) of the statutes is amended to read:

609.32 **(2)** (c) A ~~managed care~~ defined network plan may not require a participating provider to provide services that are outside the scope of his or her license or certificate.

SECTION 3741mmt. 609.34 of the statutes is renumbered 609.34 (1) and amended to read:

609.34 **(1)** A ~~managed care~~ defined network plan shall appoint a physician as medical director. The medical director shall be responsible for clinical protocols, quality assurance activities, and utilization management policies of the plan.

SECTION 3741mmx. 609.34 (2) of the statutes is created to read:

609.34 **(2)** ~~Notwithstanding sub. (1),~~ a preferred provider plan may contract for services related to clinical protocols and utilization management. A preferred provider plan or its designee is required to appoint a medical director only to the extent that the preferred provider plan or its designee assumes direct responsibility for clinical protocols and utilization management policies of the plan. The medical director, who shall be a physician, shall be responsible for such protocols and policies of the plan.

SECTION 3741mmy. 609.35 of the statutes is created to read:

609.35 Applicability of requirements to preferred provider plans. Notwithstanding ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1).

SECTION 3741mmz. 609.36 (1) (a) (intro.) of the statutes is amended to read:

609.36 **(1)** (a) (intro.) A ~~managed care~~ defined network plan shall provide to the commissioner information related to all of the following:

SECTION 3741nmg. 609.36 (2) of the statutes is amended to read:

609.36 **(2)** CONFIDENTIALITY. A ~~managed care~~ defined network plan shall establish written policies and procedures, consistent with ss. 51.30, 146.82, and

252.15, for the handling of medical records and enrollee communications to ensure confidentiality.

SECTION 3741nmp. 609.38 of the statutes is amended to read:

609.38 Oversight. The office shall perform examinations of insurers that issue ~~managed care~~ defined network plans consistent with ss. 601.43 and 601.44. The commissioner shall by rule develop standards for ~~managed care~~ defined network plans for compliance with the requirements under this chapter.

SECTION 3741nmt. 609.65 (1) (intro.) of the statutes is amended to read:

609.65 **(1)** (intro.) If an enrollee of a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is examined, evaluated, or treated for a nervous or mental disorder pursuant to an emergency detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m) or (4r) or ch. 980, then, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) to (4) and 609.05 (3), the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall do all of the following:

SECTION 3741omg. 609.65 (1) (a) of the statutes is amended to read:

609.65 **(1)** (a) If the provider performing the examination, evaluation, or treatment has a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the provision of that service to the enrollee, make the service available to the enrollee in accordance with the terms of the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan and the provider agreement.

SECTION 3741omp. 609.65 (1) (b) (intro.) of the statutes is amended to read:

609.65 **(1)** (b) (intro.) If the provider performing the examination, evaluation or treatment does not have a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the provision of that service to the enrollee, reimburse the provider for the examination, evaluation, or treatment of the enrollee in an amount not to exceed the maximum reimbursement for the service under the medical assistance program under subch. IV of ch. 49, if any of the following applies:

SECTION 3741omt. 609.65 (1) (b) 1. of the statutes is amended to read:

609.65 **(1)** (b) 1. The service is provided pursuant to a commitment or a court order, except that reimbursement is not required under this subdivision if the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan could have provided the service through a provider with whom it has a provider agreement.

SECTION 3741pmg. 609.65 (1) (b) 2. of the statutes is amended to read:

609.65 **(1)** (b) 2. The service is provided pursuant to an emergency detention under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20 and the provider notifies the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan within 72 hours after the initial provision of the service.

SECTION 3741pmp. 609.65 (2) of the statutes is amended to read:

609.65 **(2)** If after receiving notice under sub. (1) (b) 2. the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan arranges for services to be provided by a provider with whom it has a provider agreement, the limited service health organization, preferred provider plan, or

~~managed care~~ plan is not required to reimburse a provider under sub. (1) (b) 2. for any services provided after arrangements are made under this subsection.

SECTION 3741pmt. 609.65 (3) of the statutes is amended to read:

609.65 **(3)** A limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is only required to make available, or make reimbursement for, an examination, evaluation, or treatment under sub. (1) to the extent that the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan would have made the medically necessary service available to the enrollee or reimbursed the provider for the service if any referrals required under s. 609.05 (3) had been made and the service had been performed by a participating provider.

SECTION 3741qmg. 609.655 (1) (a) 1. of the statutes is amended to read:

609.655 **(1)** (a) 1. Is covered as a dependent child under the terms of a policy or certificate issued by a ~~managed care~~ defined network plan insurer.

SECTION 3741qmp. 609.655 (1) (a) 2. of the statutes is amended to read:

609.655 **(1)** (a) 2. Is enrolled in a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741qmt. 609.655 (2) of the statutes is amended to read:

609.655 **(2)** If a policy or certificate issued by a ~~managed care~~ defined network plan insurer provides coverage of outpatient services provided to a dependent student, the policy or certificate shall provide coverage of outpatient services, to the extent and in the manner required under sub. (3), that are provided to the dependent student while he or she is attending a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan,

notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) and 609.05 (3).

SECTION 3741rmg. 609.655 (3) (intro.) of the statutes is amended to read:

609.655 **(3)** (intro.) Except as provided in sub. (5), a ~~managed care~~ defined network plan shall provide coverage for all of the following services:

SECTION 3741rmp. 609.655 (3) (a) of the statutes is amended to read:

609.655 **(3)** (a) A clinical assessment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems, conducted by a provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and who may be designated by the ~~managed care~~ defined network plan.

SECTION 3741smg. 609.655 (3) (b) (intro.) of the statutes is amended to read:

609.655 **(3)** (b) (intro.) If outpatient services are recommended in the clinical assessment conducted under par. (a), the recommended outpatient services consisting of not more than 5 visits to an outpatient treatment facility or other provider that is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and that may be designated by the ~~managed care~~ defined network plan, except as follows:

SECTION 3741smp. 609.655 (3) (b) 1. of the statutes is amended to read:

609.655 **(3)** (b) 1. Coverage is not required under this paragraph if the medical director of the ~~managed care~~ defined network plan determines that the nature of the treatment recommended in the clinical assessment will prohibit the dependent student from attending school on a regular basis.

SECTION 3741smt. 609.655 (4) (a) of the statutes is amended to read:

609.655 **(4)** (a) Upon completion of the 5 visits for outpatient services covered under sub. (3) (b), the medical director of the ~~managed care~~ defined network plan and the clinician treating the dependent student shall review the dependent student's condition and determine whether it is appropriate to continue treatment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems in reasonably close proximity to the school in which the student is enrolled. The review is not required if the dependent student is no longer enrolled in the school or if the coverage limits under the policy or certificate for treatment of nervous or mental disorders or alcoholism or other drug abuse problems have been exhausted.

SECTION 3741tmg. 609.655 (4) (b) of the statutes is amended to read:

609.655 **(4)** (b) Upon completion of the review under par. (a), the medical director of the ~~managed care~~ defined network plan shall determine whether the policy or certificate will provide coverage of any further treatment for the dependent student's nervous or mental disorder or alcoholism or other drug abuse problems that is provided by a provider located in reasonably close proximity to the school in which the student is enrolled. If the dependent student disputes the medical director's determination, the dependent student may submit a written grievance under the ~~managed care~~ defined network plan's internal grievance procedure established under s. 632.83.

SECTION 3741tmp. 609.655 (5) (a) of the statutes is amended to read:

609.655 **(5)** (a) A policy or certificate issued by a ~~managed care~~ defined network plan insurer is required to provide coverage for the services specified in sub. (3) only to the extent that the policy or certificate would have covered the service if it had been provided to the dependent student by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741tmt. 609.655 (5) (b) of the statutes is amended to read:

609.655 **(5)** (b) Paragraph (a) does not permit a ~~managed care~~ defined network plan to reimburse a provider for less than the full cost of the services provided or an amount negotiated with the provider, solely because the reimbursement rate for the service would have been less if provided by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741umg. 609.70 of the statutes is amended to read:

609.70 Chiropractic coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.87 (3).

SECTION 3741ump. 609.75 of the statutes is amended to read:

609.75 Adopted children coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.896. Coverage of health care services obtained by adopted children and children placed for adoption may be subject to any requirements that the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained by other enrollees.

SECTION 3741umt. 609.77 of the statutes is amended to read:

609.77 Coverage of breast reconstruction. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (13).

SECTION 3741vmg. 609.78 of the statutes is amended to read:

609.78 Coverage of treatment for the correction of temporomandibular disorders. Limited service health organizations, preferred

provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (11).

SECTION 3741vmp. 609.79 of the statutes is amended to read:

609.79 Coverage of hospital and ambulatory surgery center charges and anesthetics for dental care. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (12).

SECTION 3741vmt. 609.80 of the statutes is amended to read:

609.80 Coverage of mammograms. ~~Managed care~~ Defined network plans are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be subject to any requirements that the ~~managed care~~ defined network plan imposes under s. 609.05 (2) and (3) on the coverage of other health care services obtained by enrollees.

SECTION 3741wmg. 609.81 of the statutes is amended to read:

609.81 Coverage related to HIV infection. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.93. ~~Managed care~~ Defined network plans are subject to s. 632.895 (9).

SECTION 3741wmp. 609.82 of the statutes is amended to read:

609.82 Coverage without prior authorization for emergency medical condition treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.85.

SECTION 3741wmt. 609.83 of the statutes is amended to read:

609.83 Coverage of drugs and devices. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.853.

SECTION 3741xmg. 609.84 of the statutes is amended to read:

609.84 Experimental treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.855.

SECTION 3741xmp. 609.88 of the statutes is amended to read:

609.88 Coverage of immunizations. ~~Managed care~~ Defined network plans are subject to s. 632.895 (14).

SECTION 3741xmr. 609.89 of the statutes is amended to read:

609.89 Written reason for coverage denial. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.17.

SECTION 3741xmt. 609.90 of the statutes is amended to read:

609.90 Restrictions related to domestic abuse. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.95.".

3. Page 1181, line 12: after that line insert:

"**SECTION 3763f.** 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. This paragraph applies to a ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), only

with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

SECTION 3763g. 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 ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b).".

(END)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBb1653/3dn
MGG:kmg:pg

June 27, 2001

This redraft substitutes language concerning historical societies for "as determined by the department" in s. 30.121 (3g).

Mary Gibson–Glass
Senior Legislative Attorney
Phone: (608) 267–3215

Kahler, Pam

From: Hughes, Carolyn
Sent: Thursday, June 28, 2001 1:11 PM
To: Kahler, Pam
Subject: RE: LRB Draft: 01b1515/3 Preferred provider plans

sounds good

-----Original Message-----
From: Kahler, Pam
Sent: Thursday, June 28, 2001 1:07 PM
To: Hughes, Carolyn
Subject: RE: LRB Draft: 01b1515/3 Preferred provider plans

Carolyn:
When "all" is changed to "any," it makes more sense to say "The commissioner *may* (rather that shall) promulgate rules for any of the following purposes, as appropriate:
Okay?

-----Original Message-----
From: Hughes, Carolyn
Sent: Thursday, June 28, 2001 1:01 PM
To: Kahler, Pam
Subject: FW: LRB Draft: 01b1515/3 Preferred provider plans

One more change:

Page 4 Line 17..change all to any
Page 4 Line 18..it should read following purposes as appropriate;

-----Original Message-----
From: Greenslet, Patty
Sent: Wednesday, June 27, 2001 4:39 PM
To: Hughes, Carolyn
Cc: Legislative Fiscal Bureau; Hanaman, Cathlene; Haugen, Caroline
Subject: LRB Draft: 01b1515/3 Preferred provider plans

Following is the PDF version of draft 01b1515/3.

<< File: 01b1515/3 >>

State of Wisconsin
2001 – 2002 LEGISLATURE

LRBb1515/5 4
PJK:cjs:pg

ARC:.....Hughes – AM66, Preferred provider plans

FOR 2001–03 BUDGET — NOT READY FOR INTRODUCTION

CAUCUS ASSEMBLY AMENDMENT
TO ASSEMBLY SUBSTITUTE AMENDMENT 1,
TO 2001 SENATE BILL 55

At the locations indicated, amend the substitute amendment as follows:

1. Page 534, line 23: after that line insert:

"**SECTION 1398r.** 40.51 (12) of the statutes is amended to read:

40.51 **(12)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), and every limited service health organization, as defined in s. 609.01 (3), that is offered by the state under sub. (6) shall comply with ch. 609.

SECTION 1398s. 40.51 (13) of the statutes is amended to read:

40.51 **(13)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), and every limited service health organization, as defined in s. 609.01 (3),

that is offered by the group insurance board under sub. (7) shall comply with ch. 609.".

2. Page 1180, line 21: after that line insert:

"**SECTION 3741amc.** Chapter 609 (title) of the statutes is amended to read:

CHAPTER 609

~~MANAGED CARE~~ DEFINED NETWORK PLANS

SECTION 3741amg. 609.01 (1d) of the statutes is amended to read:

609.01 **(1d)** "Enrollee" means, with respect to a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization, a person who is entitled to receive health care services under the plan.

SECTION 3741amp. 609.01 (3c) of the statutes is renumbered 609.01 (1b) and amended to read:

609.01 **(1b)** "~~Managed care~~ Defined network plan" means a health benefit plan that requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with, or employed by the insurer offering the health benefit plan.

SECTION 3741amt. 609.01 (3m) of the statutes is amended to read:

609.01 **(3m)** "Participating" means, with respect to a physician or other provider, under contract with a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to provide health care services, items or supplies to enrollees of the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization.

SECTION 3741bmg. 609.01 (4) of the statutes is amended to read:

609.01 **(4)** "Preferred provider plan" means a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, 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 ~~participating in the plan~~.

SECTION 3741bmp. 609.01 (5) of the statutes is amended to read:

609.01 **(5)** "Primary provider" means a participating primary care physician, or other participating provider authorized by the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to serve as a primary provider, who coordinates and may provide ongoing care to an enrollee.

SECTION 3741bmt. 609.05 (1) of the statutes is amended to read:

609.05 **(1)** Except as provided in subs. (2) and (3), a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall permit its enrollees to choose freely among participating providers.

SECTION 3741cmg. 609.05 (2) of the statutes is amended to read:

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

SECTION 3741cmp. 609.05 (3) of the statutes is amended to read:

609.05 **(3)** Except as provided in ss. 609.22 (4m), 609.65, and 609.655, a limited service health organization, preferred provider plan, or ~~managed care~~ defined

network plan may require an enrollee to obtain a referral from the primary provider designated under sub. (2) to another participating provider prior to obtaining health care services from that participating provider.

SECTION 3741cmt. 609.17 of the statutes is amended to read:

609.17 Reports of disciplinary action. Every limited service health organization, preferred provider plan, and ~~managed care~~ defined network plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a participating provider who holds a license or certificate granted by the board or affiliated credentialing board.

SECTION 3741dmg. 609.20 (title) of the statutes is amended to read:

609.20 (title) **Rules for preferred provider and ~~managed care~~ defined network plans.**

SECTION 3741dmp. 609.20 (intro.) of the statutes is renumbered 609.20 (1m) (intro.) and amended to read:

609.20 **(1m)** (intro.) The commissioner ~~shall~~ promulgate rules relating to preferred provider plans and ~~managed care~~ defined network plans for ~~all~~ of the following purposes, as appropriate:

SECTION 3741dmt. 609.20 (1) of the statutes is renumbered 609.20 (1m) (a).

SECTION 3741emg. 609.20 (2) of the statutes is renumbered 609.20 (1m) (b).

SECTION 3741emp. 609.20 (2m) of the statutes is created to read:

609.20 **(2m)** Any rule promulgated under this chapter shall recognize the differences between preferred provider plans and other types of defined network plans, take into account the fact that preferred provider plans provide coverage for

the services of nonparticipating providers, and be appropriate to the type of plan to which the rule applies.

SECTION 3741emt. 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act 9, is renumbered 609.20 (1m) (c).

SECTION 3741fmg. 609.20 (4) of the statutes, as affected by 2001 Wisconsin Act 9, is renumbered 609.20 (1m) (d).

SECTION 3741fmp. 609.22 (1) of the statutes is amended to read:

609.22 **(1)** PROVIDERS. A ~~managed care~~ defined network plan shall include a sufficient number, and sufficient types, of qualified providers to meet the anticipated needs of its enrollees, with respect to covered benefits, as appropriate to the type of plan and consistent with normal practices and standards in the geographic area.

SECTION 3741fmt. 609.22 (2) of the statutes is amended to read:

609.22 **(2)** ADEQUATE CHOICE. A ~~managed care~~ defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are accessible and qualified.

SECTION 3741gmg. 609.22 (3) of the statutes is amended to read:

609.22 **(3)** PRIMARY PROVIDER SELECTION. A ~~managed care~~ defined network plan that is not a preferred provider plan shall permit each enrollee to select his or her own primary provider from a list of participating primary care physicians and any other participating providers that are authorized by the ~~managed care~~ defined network plan to serve as primary providers. The list shall be updated on an ongoing basis and shall include a sufficient number of primary care physicians and any other participating providers authorized by the plan to serve as primary providers who are accepting new enrollees.

SECTION 3741gmp. 609.22 (4) (a) 1. of the statutes is amended to read:

609.22 **(4)** (a) 1. If a ~~managed care~~ defined network plan that is not a preferred provider plan requires a referral to a specialist for coverage of specialist services, the ~~managed care~~ defined network plan that is not a preferred provider plan shall establish a procedure by which an enrollee may apply for a standing referral to a specialist. The procedure must specify the criteria and conditions that must be met in order for an enrollee to obtain a standing referral.

SECTION 3741gmt. 609.22 (4) (a) 2. of the statutes is amended to read:

609.22 **(4)** (a) 2. A ~~managed care~~ defined network plan that is not a preferred provider plan may require the enrollee's primary provider to remain responsible for coordinating the care of an enrollee who receives a standing referral to a specialist. A ~~managed care~~ defined network plan that is not a preferred provider plan may restrict the specialist from making any secondary referrals without prior approval by the enrollee's primary provider. If an enrollee requests primary care services from a specialist to whom the enrollee has a standing referral, the specialist, in agreement with the enrollee and the enrollee's primary provider, may provide primary care services to the enrollee in accordance with procedures established by the ~~managed care~~ defined network plan that is not a preferred provider plan.

SECTION 3741hmg. 609.22 (4) (a) 3. of the statutes is amended to read:

609.22 **(4)** (a) 3. A ~~managed care~~ defined network plan that is not a preferred provider plan must include information regarding referral procedures in policies or certificates provided to enrollees and must provide such information to an enrollee or prospective enrollee upon request.

SECTION 3741hmp. 609.22 (4m) (a) of the statutes is amended to read:

609.22 **(4m)** (a) A ~~managed care~~ defined network plan that provides coverage of obstetric or gynecologic services may not require a female enrollee of the ~~managed care~~ defined network plan to obtain a referral for covered obstetric or gynecologic benefits provided by a participating provider who is a physician licensed under ch. 448 and who specializes in obstetrics and gynecology, regardless of whether the participating provider is the enrollee's primary provider. Notwithstanding sub. (4), the ~~managed care~~ defined network plan may not require the enrollee to obtain a standing referral under the procedure established under sub. (4) (a) for covered obstetric or gynecologic benefits.

SECTION 3741hmt. 609.22 (4m) (b) (intro.) of the statutes is amended to read:

609.22 **(4m)** (b) (intro.) A ~~managed care~~ defined network plan under par. (a) may not do any of the following:

SECTION 3741img. 609.22 (4m) (c) of the statutes is amended to read:

609.22 **(4m)** (c) A ~~managed care~~ defined network plan under par. (a) shall provide written notice of the requirement under par. (a) in every policy or group certificate issued by the ~~managed care~~ defined network plan.

SECTION 3741imp. 609.22 (5) of the statutes is amended to read:

609.22 **(5)** SECOND OPINIONS. A ~~managed care~~ defined network plan shall provide an enrollee with coverage for a 2nd opinion from another participating provider.

SECTION 3741imt. 609.22 (6) (intro.) of the statutes is amended to read:

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

SECTION 3741jmg. 609.22 (7) of the statutes is amended to read:

609.22 **(7)** TELEPHONE ACCESS. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide telephone access for sufficient time during business and evening hours to ensure that enrollees have adequate access to routine health care services for which coverage is provided under the plan. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide 24–hour telephone access to the plan or to a participating provider for emergency care, or authorization for care, for which coverage is provided under the plan.

SECTION 3741jmp. 609.22 (8) of the statutes is amended to read:

609.22 **(8)** ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed care~~ defined network plan shall develop an access plan to meet the needs, with respect to covered benefits, of its enrollees who are members of underserved populations. If a significant number of enrollees of the plan customarily use languages other than English, the ~~managed care~~ defined network plan shall provide access to translation services fluent in those languages to the greatest extent possible.

SECTION 3741jmt. 609.24 (1) (a) (intro.) of the statutes is amended to read:

609.24 **(1)** (a) (intro.) Subject to pars. (b) and (c) and except as provided in par. (d), a ~~managed care~~ defined network plan shall, with respect to covered benefits, provide coverage to an enrollee for the services of a provider, regardless of whether the provider is a participating provider at the time the services are provided, if the ~~managed care~~ defined network plan represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the enrollee at any of the following times:

SECTION 3741kmg. 609.24 (1) (b) (intro.) of the statutes is amended to read:

609.24 **(1)** (b) (intro.) Except as provided in par. (d), a ~~managed care~~ defined network plan shall provide the coverage required under par. (a) with respect to the services of a provider who is a primary care physician for the following period of time:

SECTION 3741kmp. 609.24 (1) (c) (intro.) of the statutes is amended to read:

609.24 **(1)** (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing a course of treatment with a participating provider who is not a primary care physician and whose participation with the plan terminates, the ~~managed care~~ defined network plan shall provide the coverage under par. (a) with respect to the services of the provider for the following period of time:

SECTION 3741kmt. 609.24 (1) (d) 1. of the statutes is amended to read:

609.24 **(1)** (d) 1. The provider no longer practices in the ~~managed care~~ defined network plan's geographic service area.

SECTION 3741Lmg. 609.24 (1) (d) 2. of the statutes is amended to read:

609.24 **(1)** (d) 2. The insurer issuing the ~~managed care~~ defined network plan terminates or terminated the provider's contract for misconduct on the part of the provider.

SECTION 3471Lmp. 609.24 (1) (e) 1. of the statutes is amended to read:

609.24 **(1)** (e) 1. An insurer issuing a ~~managed care~~ defined network plan shall include in its provider contracts provisions addressing reimbursement to providers for services rendered under this section.

SECTION 3741Lmt. 609.24 (1) (e) 2. of the statutes is amended to read:

609.24 **(1)** (e) 2. If a contract between a ~~managed care~~ defined network plan and a provider does not address reimbursement for services rendered under this section, the insurer shall reimburse the provider according to the most recent contracted rate.

SECTION 3741mmb. 609.24 (4) of the statutes is created to read:

609.24 **(4)** NOTICE OF PROVISIONS. A defined network plan shall notify all plan enrollees of the provisions under this section whenever a participating provider's participation with the plan terminates, or shall, by contract, require a participating provider to notify all plan enrollees of the provisions under this section if the participating provider's participation with the plan terminates.

SECTION 3741mmd. 609.30 (1) of the statutes is amended to read:

609.30 **(1)** PLAN MAY NOT CONTRACT. A ~~managed care~~ defined network plan may not contract with a participating provider to limit the provider's disclosure of information, to or on behalf of an enrollee, about the enrollee's medical condition or treatment options.

SECTION 3741mmf. 609.30 (2) of the statutes is amended to read:

609.30 **(2)** PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provider determines to be in the best interest of the enrollee. A ~~managed care~~ defined network plan may not penalize or terminate the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee.

SECTION 3741mmh. 609.32 (1) (intro.) of the statutes is amended to read:

609.32 **(1)** STANDARDS; OTHER THAN PREFERRED PROVIDER PLANS. (intro.) A ~~managed care~~ defined network plan that is not a preferred provider plan shall develop comprehensive quality assurance standards that are adequate to identify, evaluate, and remedy problems related to access to, and continuity and quality of, care. The standards shall include at least all of the following:

SECTION 3741mmj. 609.32 (1m) of the statutes is created to read:

609.32 **(1m)** PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A preferred provider plan shall develop a procedure for remedial action to address quality problems, including written procedures for taking appropriate corrective action.

SECTION 3741mmn. 609.32 (2) (a) of the statutes is amended to read:

609.32 **(2)** (a) A ~~managed care~~ defined network plan shall develop a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

SECTION 3741mmp. 609.32 (2) (b) (intro.) of the statutes is amended to read:

609.32 **(2)** (b) (intro.) A ~~managed care~~ defined network plan shall establish in writing a formal, ongoing process for reevaluating each participating provider within a specified number of years after the provider's initial acceptance for participation. The reevaluation shall include all of the following:

SECTION 3741mmr. 609.32 (2) (c) of the statutes is amended to read:

609.32 **(2)** (c) A ~~managed care~~ defined network plan may not require a participating provider to provide services that are outside the scope of his or her license or certificate.

SECTION 3741mmt. 609.34 of the statutes is renumbered 609.34 (1) and amended to read:

609.34 **(1)** A ~~managed care~~ defined network plan that is not a preferred provider plan shall appoint a physician as medical director. The medical director shall be responsible for clinical protocols, quality assurance activities, and utilization management policies of the plan.

SECTION 3741mmx. 609.34 (2) of the statutes is created to read:

609.34 **(2)** A preferred provider plan may contract for services related to clinical protocols and utilization management. A preferred provider plan or its designee is required to appoint a medical director only to the extent that the preferred provider plan or its designee assumes direct responsibility for clinical protocols and utilization management policies of the plan. The medical director, who shall be a physician, shall be responsible for such protocols and policies of the plan.

SECTION 3741mmy. 609.35 of the statutes is created to read:

609.35 Applicability of requirements to preferred provider plans. Notwithstanding ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to the requirements under ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1).

SECTION 3741mmz. 609.36 (1) (a) (intro.) of the statutes is amended to read:

609.36 **(1)** (a) (intro.) A ~~managed care~~ defined network plan shall provide to the commissioner information related to all of the following:

SECTION 3741nmg. 609.36 (2) of the statutes is amended to read:

609.36 **(2)** CONFIDENTIALITY. A ~~managed care~~ defined network plan shall establish written policies and procedures, consistent with ss. 51.30, 146.82, and

252.15, for the handling of medical records and enrollee communications to ensure confidentiality.

SECTION 3741nmp. 609.38 of the statutes is amended to read:

609.38 Oversight. The office shall perform examinations of insurers that issue ~~managed care~~ defined network plans consistent with ss. 601.43 and 601.44. The commissioner shall by rule develop standards for ~~managed care~~ defined network plans for compliance with the requirements under this chapter.

SECTION 3741nmt. 609.65 (1) (intro.) of the statutes is amended to read:

609.65 **(1)** (intro.) If an enrollee of a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is examined, evaluated, or treated for a nervous or mental disorder pursuant to an emergency detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m) or (4r) or ch. 980, then, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) to (4) and 609.05 (3), the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall do all of the following:

SECTION 3741omg. 609.65 (1) (a) of the statutes is amended to read:

609.65 **(1)** (a) If the provider performing the examination, evaluation, or treatment has a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the provision of that service to the enrollee, make the service available to the enrollee in accordance with the terms of the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan and the provider agreement.

SECTION 3741omp. 609.65 (1) (b) (intro.) of the statutes is amended to read:

609.65 **(1)** (b) (intro.) If the provider performing the examination, evaluation or treatment does not have a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the provision of that service to the enrollee, reimburse the provider for the examination, evaluation, or treatment of the enrollee in an amount not to exceed the maximum reimbursement for the service under the medical assistance program under subch. IV of ch. 49, if any of the following applies:

SECTION 3741omt. 609.65 (1) (b) 1. of the statutes is amended to read:

609.65 **(1)** (b) 1. The service is provided pursuant to a commitment or a court order, except that reimbursement is not required under this subdivision if the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan could have provided the service through a provider with whom it has a provider agreement.

SECTION 3741pmg. 609.65 (1) (b) 2. of the statutes is amended to read:

609.65 **(1)** (b) 2. The service is provided pursuant to an emergency detention under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20 and the provider notifies the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan within 72 hours after the initial provision of the service.

SECTION 3741pmp. 609.65 (2) of the statutes is amended to read:

609.65 **(2)** If after receiving notice under sub. (1) (b) 2. the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan arranges for services to be provided by a provider with whom it has a provider agreement, the limited service health organization, preferred provider plan, or

~~managed care~~ plan is not required to reimburse a provider under sub. (1) (b) 2. for any services provided after arrangements are made under this subsection.

SECTION 3741pmt. 609.65 (3) of the statutes is amended to read:

609.65 **(3)** A limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is only required to make available, or make reimbursement for, an examination, evaluation, or treatment under sub. (1) to the extent that the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan would have made the medically necessary service available to the enrollee or reimbursed the provider for the service if any referrals required under s. 609.05 (3) had been made and the service had been performed by a participating provider.

SECTION 3741qmg. 609.655 (1) (a) 1. of the statutes is amended to read:

609.655 **(1)** (a) 1. Is covered as a dependent child under the terms of a policy or certificate issued by a ~~managed care~~ defined network plan insurer.

SECTION 3741qmp. 609.655 (1) (a) 2. of the statutes is amended to read:

609.655 **(1)** (a) 2. Is enrolled in a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741qmt. 609.655 (2) of the statutes is amended to read:

609.655 **(2)** If a policy or certificate issued by a ~~managed care~~ defined network plan insurer provides coverage of outpatient services provided to a dependent student, the policy or certificate shall provide coverage of outpatient services, to the extent and in the manner required under sub. (3), that are provided to the dependent student while he or she is attending a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan,

notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) and 609.05 (3).

SECTION 3741rmg. 609.655 (3) (intro.) of the statutes is amended to read:

609.655 **(3)** (intro.) Except as provided in sub. (5), a ~~managed care~~ defined network plan shall provide coverage for all of the following services:

SECTION 3741rmp. 609.655 (3) (a) of the statutes is amended to read:

609.655 **(3)** (a) A clinical assessment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems, conducted by a provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and who may be designated by the ~~managed care~~ defined network plan.

SECTION 3741smg. 609.655 (3) (b) (intro.) of the statutes is amended to read:

609.655 **(3)** (b) (intro.) If outpatient services are recommended in the clinical assessment conducted under par. (a), the recommended outpatient services consisting of not more than 5 visits to an outpatient treatment facility or other provider that is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and that may be designated by the ~~managed care~~ defined network plan, except as follows:

SECTION 3741smp. 609.655 (3) (b) 1. of the statutes is amended to read:

609.655 **(3)** (b) 1. Coverage is not required under this paragraph if the medical director of the ~~managed care~~ defined network plan determines that the nature of the treatment recommended in the clinical assessment will prohibit the dependent student from attending school on a regular basis.

SECTION 3741smt. 609.655 (4) (a) of the statutes is amended to read:

609.655 **(4)** (a) Upon completion of the 5 visits for outpatient services covered under sub. (3) (b), the medical director of the ~~managed care~~ defined network plan and the clinician treating the dependent student shall review the dependent student's condition and determine whether it is appropriate to continue treatment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems in reasonably close proximity to the school in which the student is enrolled. The review is not required if the dependent student is no longer enrolled in the school or if the coverage limits under the policy or certificate for treatment of nervous or mental disorders or alcoholism or other drug abuse problems have been exhausted.

SECTION 3741tmg. 609.655 (4) (b) of the statutes is amended to read:

609.655 **(4)** (b) Upon completion of the review under par. (a), the medical director of the ~~managed care~~ defined network plan shall determine whether the policy or certificate will provide coverage of any further treatment for the dependent student's nervous or mental disorder or alcoholism or other drug abuse problems that is provided by a provider located in reasonably close proximity to the school in which the student is enrolled. If the dependent student disputes the medical director's determination, the dependent student may submit a written grievance under the ~~managed care~~ defined network plan's internal grievance procedure established under s. 632.83.

SECTION 3741tmp. 609.655 (5) (a) of the statutes is amended to read:

609.655 **(5)** (a) A policy or certificate issued by a ~~managed care~~ defined network plan insurer is required to provide coverage for the services specified in sub. (3) only to the extent that the policy or certificate would have covered the service if it had been provided to the dependent student by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741tmt. 609.655 (5) (b) of the statutes is amended to read:

609.655 **(5)** (b) Paragraph (a) does not permit a ~~managed care~~ defined network plan to reimburse a provider for less than the full cost of the services provided or an amount negotiated with the provider, solely because the reimbursement rate for the service would have been less if provided by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741umg. 609.70 of the statutes is amended to read:

609.70 Chiropractic coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.87 (3).

SECTION 3741ump. 609.75 of the statutes is amended to read:

609.75 Adopted children coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.896. Coverage of health care services obtained by adopted children and children placed for adoption may be subject to any requirements that the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained by other enrollees.

SECTION 3741umt. 609.77 of the statutes is amended to read:

609.77 Coverage of breast reconstruction. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (13).

SECTION 3741vmg. 609.78 of the statutes is amended to read:

609.78 Coverage of treatment for the correction of temporomandibular disorders. Limited service health organizations, preferred

provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (11).

SECTION 3741vmp. 609.79 of the statutes is amended to read:

609.79 Coverage of hospital and ambulatory surgery center charges and anesthetics for dental care. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (12).

SECTION 3741vmt. 609.80 of the statutes is amended to read:

609.80 Coverage of mammograms. ~~Managed care~~ Defined network plans are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be subject to any requirements that the ~~managed care~~ defined network plan imposes under s. 609.05 (2) and (3) on the coverage of other health care services obtained by enrollees.

SECTION 3741wmg. 609.81 of the statutes is amended to read:

609.81 Coverage related to HIV infection. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.93. ~~Managed care~~ Defined network plans are subject to s. 632.895 (9).

SECTION 3741wmp. 609.82 of the statutes is amended to read:

609.82 Coverage without prior authorization for emergency medical condition treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.85.

SECTION 3741wmt. 609.83 of the statutes is amended to read:

609.83 Coverage of drugs and devices. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.853.

SECTION 3741xmg. 609.84 of the statutes is amended to read:

609.84 Experimental treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.855.

SECTION 3741xmp. 609.88 of the statutes is amended to read:

609.88 Coverage of immunizations. ~~Managed care~~ Defined network plans are subject to s. 632.895 (14).

SECTION 3741xmr. 609.89 of the statutes is amended to read:

609.89 Written reason for coverage denial. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.17.

SECTION 3741xmt. 609.90 of the statutes is amended to read:

609.90 Restrictions related to domestic abuse. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.95.".

3. Page 1181, line 12: after that line insert:

"**SECTION 3763f.** 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. This paragraph applies to a ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3e)~~ (1b), only

with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

SECTION 3763g. 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 ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b).".

(END)

insert 4-3

3741cmr

(CS)

Section #. 609.10 (5) of the statutes is amended to read:

any

strike

609.10 **(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; 1997 a. 237; 1999 a. 9.~~

(and 5) ins 4-3)

LRB 1515/4
PJK:cjs:

D-note

¶ This redraft makes some language changes in s. 609.20(1m) (intro.) (as renumbered) regarding the rule-making requirement under current law, and amends s. 609.10(5) for consistency with those changes. PJK

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBb1515/4dn
PJK:cjs:kjf

June 28, 2001

This redraft makes some language changes in s. 609.20 (1m) (intro.) (as renumbered), regarding the rule–making requirement under current law, and amends s. 609.10 (5) for consistency with those changes.

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

State of Wisconsin
2001 – 2002 LEGISLATURE

LRBb1515/4
PJK:cjs:kjf

ARC:.....Hughes – AM66, Preferred provider plans

FOR 2001–03 BUDGET — NOT READY FOR INTRODUCTION

CAUCUS ASSEMBLY AMENDMENT
TO ASSEMBLY SUBSTITUTE AMENDMENT 1,
TO 2001 SENATE BILL 55

At the locations indicated, amend the substitute amendment as follows:

1. Page 534, line 23: after that line insert:

"**SECTION 1398r.** 40.51 (12) of the statutes is amended to read:

40.51 **(12)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), and every limited service health organization, as defined in s. 609.01 (3), that is offered by the state under sub. (6) shall comply with ch. 609.

SECTION 1398s. 40.51 (13) of the statutes is amended to read:

40.51 **(13)** Every ~~managed care~~ defined network plan, as defined in s. 609.01 (3c) (1b), and every limited service health organization, as defined in s. 609.01 (3),

that is offered by the group insurance board under sub. (7) shall comply with ch. 609.".

2. Page 1180, line 21: after that line insert:

"**SECTION 3741amc.** Chapter 609 (title) of the statutes is amended to read:

CHAPTER 609

~~MANAGED CARE~~ DEFINED NETWORK PLANS

SECTION 3741amg. 609.01 (1d) of the statutes is amended to read:

609.01 **(1d)** "Enrollee" means, with respect to a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization, a person who is entitled to receive health care services under the plan.

SECTION 3741amp. 609.01 (3c) of the statutes is renumbered 609.01 (1b) and amended to read:

609.01 **(1b)** "~~Managed care~~ Defined network plan" means a health benefit plan that requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with, or employed by the insurer offering the health benefit plan.

SECTION 3741amt. 609.01 (3m) of the statutes is amended to read:

609.01 **(3m)** "Participating" means, with respect to a physician or other provider, under contract with a ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to provide health care services, items or supplies to enrollees of the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization.

SECTION 3741bmg. 609.01 (4) of the statutes is amended to read:

609.01 **(4)** "Preferred provider plan" means a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, 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 ~~participating in the plan~~.

SECTION 3741bmp. 609.01 (5) of the statutes is amended to read:

609.01 **(5)** "Primary provider" means a participating primary care physician, or other participating provider authorized by the ~~managed care~~ defined network plan, preferred provider plan, or limited service health organization to serve as a primary provider, who coordinates and may provide ongoing care to an enrollee.

SECTION 3741bmt. 609.05 (1) of the statutes is amended to read:

609.05 **(1)** Except as provided in subs. (2) and (3), a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall permit its enrollees to choose freely among participating providers.

SECTION 3741cmg. 609.05 (2) of the statutes is amended to read:

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

SECTION 3741cmp. 609.05 (3) of the statutes is amended to read:

609.05 **(3)** Except as provided in ss. 609.22 (4m), 609.65, and 609.655, a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan may require an enrollee to obtain a referral from the primary provider

designated under sub. (2) to another participating provider prior to obtaining health care services from that participating provider.

SECTION 3741cmr. 609.10 (5) of the statutes is amended to read:

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

SECTION 3741cmt. 609.17 of the statutes is amended to read:

609.17 Reports of disciplinary action. Every limited service health organization, preferred provider plan, and ~~managed care~~ defined network plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a participating provider who holds a license or certificate granted by the board or affiliated credentialing board.

SECTION 3741dmg. 609.20 (title) of the statutes is amended to read:

609.20 (title) **Rules for preferred provider and ~~managed care~~ defined network plans.**

SECTION 3741dmp. 609.20 (intro.) of the statutes is renumbered 609.20 (1m) (intro.) and amended to read:

609.20 **(1m)** (intro.) The commissioner ~~shall~~ may promulgate rules relating to preferred provider plans and ~~managed care~~ defined network plans for ~~all~~ any of the following purposes, as appropriate:

SECTION 3741dmt. *609.20 (1) of the statutes is renumbered 609.20 (1m) (a).*

SECTION 3741emg. 609.20 (2) of the statutes is renumbered 609.20 (1m) (b).

SECTION 3741emp. 609.20 (2m) of the statutes is created to read:

609.20 **(2m)** Any rule promulgated under this chapter shall recognize the differences between preferred provider plans and other types of defined network plans, take into account the fact that preferred provider plans provide coverage for the services of nonparticipating providers, and be appropriate to the type of plan to which the rule applies.

SECTION 3741emt. 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act 9, is renumbered 609.20 (1m) (c).

SECTION 3741fmg. 609.20 (4) of the statutes, as affected by 2001 Wisconsin Act 9, is renumbered 609.20 (1m) (d).

SECTION 3741fmp. 609.22 (1) of the statutes is amended to read:

609.22 **(1)** PROVIDERS. A ~~managed care~~ defined network plan shall include a sufficient number, and sufficient types, of qualified providers to meet the anticipated needs of its enrollees, with respect to covered benefits, as appropriate to the type of plan and consistent with normal practices and standards in the geographic area.

SECTION 3741fmt. 609.22 (2) of the statutes is amended to read:

609.22 **(2)** ADEQUATE CHOICE. A ~~managed care~~ defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are accessible and qualified.

SECTION 3741gmg. 609.22 (3) of the statutes is amended to read:

609.22 **(3)** PRIMARY PROVIDER SELECTION. A ~~managed care~~ defined network plan that is not a preferred provider plan shall permit each enrollee to select his or her own primary provider from a list of participating primary care physicians and any other participating providers that are authorized by the ~~managed care~~ defined network plan to serve as primary providers. The list shall be updated on an ongoing

basis and shall include a sufficient number of primary care physicians and any other participating providers authorized by the plan to serve as primary providers who are accepting new enrollees.

SECTION 3741gmp. 609.22 (4) (a) 1. of the statutes is amended to read:

609.22 **(4)** (a) 1. If a ~~managed care~~ defined network plan that is not a preferred provider plan requires a referral to a specialist for coverage of specialist services, the ~~managed care~~ defined network plan that is not a preferred provider plan shall establish a procedure by which an enrollee may apply for a standing referral to a specialist. The procedure must specify the criteria and conditions that must be met in order for an enrollee to obtain a standing referral.

SECTION 3741gmt. 609.22 (4) (a) 2. of the statutes is amended to read:

609.22 **(4)** (a) 2. A ~~managed care~~ defined network plan that is not a preferred provider plan may require the enrollee's primary provider to remain responsible for coordinating the care of an enrollee who receives a standing referral to a specialist. A ~~managed care~~ defined network plan that is not a preferred provider plan may restrict the specialist from making any secondary referrals without prior approval by the enrollee's primary provider. If an enrollee requests primary care services from a specialist to whom the enrollee has a standing referral, the specialist, in agreement with the enrollee and the enrollee's primary provider, may provide primary care services to the enrollee in accordance with procedures established by the ~~managed care~~ defined network plan that is not a preferred provider plan.

SECTION 3741hmg. 609.22 (4) (a) 3. of the statutes is amended to read:

609.22 **(4)** (a) 3. A ~~managed care~~ defined network plan that is not a preferred provider plan must include information regarding referral procedures in policies or

certificates provided to enrollees and must provide such information to an enrollee or prospective enrollee upon request.

SECTION 3741hmp. 609.22 (4m) (a) of the statutes is amended to read:

609.22 **(4m)** (a) A ~~managed care~~ defined network plan that provides coverage of obstetric or gynecologic services may not require a female enrollee of the ~~managed care~~ defined network plan to obtain a referral for covered obstetric or gynecologic benefits provided by a participating provider who is a physician licensed under ch. 448 and who specializes in obstetrics and gynecology, regardless of whether the participating provider is the enrollee's primary provider. Notwithstanding sub. (4), the ~~managed care~~ defined network plan may not require the enrollee to obtain a standing referral under the procedure established under sub. (4) (a) for covered obstetric or gynecologic benefits.

SECTION 3741hmt. 609.22 (4m) (b) (intro.) of the statutes is amended to read:

609.22 **(4m)** (b) (intro.) A ~~managed care~~ defined network plan under par. (a) may not do any of the following:

SECTION 3741img. 609.22 (4m) (c) of the statutes is amended to read:

609.22 **(4m)** (c) A ~~managed care~~ defined network plan under par. (a) shall provide written notice of the requirement under par. (a) in every policy or group certificate issued by the ~~managed care~~ defined network plan.

SECTION 3741imp. 609.22 (5) of the statutes is amended to read:

609.22 **(5)** SECOND OPINIONS. A ~~managed care~~ defined network plan shall provide an enrollee with coverage for a 2nd opinion from another participating provider.

SECTION 3741imt. 609.22 (6) (intro.) of the statutes is amended to read:

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

SECTION 3741jmg. 609.22 (7) of the statutes is amended to read:

609.22 **(7)** TELEPHONE ACCESS. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide telephone access for sufficient time during business and evening hours to ensure that enrollees have adequate access to routine health care services for which coverage is provided under the plan. A ~~managed care~~ defined network plan that is not a preferred provider plan shall provide 24–hour telephone access to the plan or to a participating provider for emergency care, or authorization for care, for which coverage is provided under the plan.

SECTION 3741jmp. 609.22 (8) of the statutes is amended to read:

609.22 **(8)** ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed care~~ defined network plan shall develop an access plan to meet the needs, with respect to covered benefits, of its enrollees who are members of underserved populations. If a significant number of enrollees of the plan customarily use languages other than English, the ~~managed care~~ defined network plan shall provide access to translation services fluent in those languages to the greatest extent possible.

SECTION 3741jmt. 609.24 (1) (a) (intro.) of the statutes is amended to read:

609.24 **(1)** (a) (intro.) Subject to pars. (b) and (c) and except as provided in par. (d), a ~~managed care~~ defined network plan shall, with respect to covered benefits, provide coverage to an enrollee for the services of a provider, regardless of whether the provider is a participating provider at the time the services are provided, if the ~~managed care~~ defined network plan represented that the provider was, or would be,

a participating provider in marketing materials that were provided or available to the enrollee at any of the following times:

SECTION 3741kmg. 609.24 (1) (b) (intro.) of the statutes is amended to read:

609.24 **(1)** (b) (intro.) Except as provided in par. (d), a ~~managed care~~ defined network plan shall provide the coverage required under par. (a) with respect to the services of a provider who is a primary care physician for the following period of time:

SECTION 3741kmp. 609.24 (1) (c) (intro.) of the statutes is amended to read:

609.24 **(1)** (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing a course of treatment with a participating provider who is not a primary care physician and whose participation with the plan terminates, the ~~managed care~~ defined network plan shall provide the coverage under par. (a) with respect to the services of the provider for the following period of time:

SECTION 3741kmt. 609.24 (1) (d) 1. of the statutes is amended to read:

609.24 **(1)** (d) 1. The provider no longer practices in the ~~managed care~~ defined network plan's geographic service area.

SECTION 3741Lmg. 609.24 (1) (d) 2. of the statutes is amended to read:

609.24 **(1)** (d) 2. The insurer issuing the ~~managed care~~ defined network plan terminates or terminated the provider's contract for misconduct on the part of the provider.

SECTION 3471Lmp. 609.24 (1) (e) 1. of the statutes is amended to read:

609.24 **(1)** (e) 1. An insurer issuing a ~~managed care~~ defined network plan shall include in its provider contracts provisions addressing reimbursement to providers for services rendered under this section.

SECTION 3741Lmt. 609.24 (1) (e) 2. of the statutes is amended to read:

609.24 **(1)** (e) 2. If a contract between a ~~managed care~~ defined network plan and a provider does not address reimbursement for services rendered under this section, the insurer shall reimburse the provider according to the most recent contracted rate.

SECTION 3741mmb. 609.24 (4) of the statutes is created to read:

609.24 **(4)** NOTICE OF PROVISIONS. A defined network plan shall notify all plan enrollees of the provisions under this section whenever a participating provider's participation with the plan terminates, or shall, by contract, require a participating provider to notify all plan enrollees of the provisions under this section if the participating provider's participation with the plan terminates.

SECTION 3741mmd. 609.30 (1) of the statutes is amended to read:

609.30 **(1)** PLAN MAY NOT CONTRACT. A ~~managed care~~ defined network plan may not contract with a participating provider to limit the provider's disclosure of information, to or on behalf of an enrollee, about the enrollee's medical condition or treatment options.

SECTION 3741mmf. 609.30 (2) of the statutes is amended to read:

609.30 **(2)** PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provider determines to be in the best interest of the enrollee. A ~~managed care~~ defined network plan may not penalize or terminate the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee.

SECTION 3741mmh. 609.32 (1) (intro.) of the statutes is amended to read:

609.32 **(1)** STANDARDS; OTHER THAN PREFERRED PROVIDER PLANS. (intro.) A ~~managed care~~ defined network plan that is not a preferred provider plan shall develop comprehensive quality assurance standards that are adequate to identify, evaluate, and remedy problems related to access to, and continuity and quality of, care. The standards shall include at least all of the following:

SECTION 3741mmj. 609.32 (1m) of the statutes is created to read:

609.32 **(1m)** PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A preferred provider plan shall develop a procedure for remedial action to address quality problems, including written procedures for taking appropriate corrective action.

SECTION 3741mmn. 609.32 (2) (a) of the statutes is amended to read:

609.32 **(2)** (a) A ~~managed care~~ defined network plan shall develop a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

SECTION 3741mmp. 609.32 (2) (b) (intro.) of the statutes is amended to read:

609.32 **(2)** (b) (intro.) A ~~managed care~~ defined network plan shall establish in writing a formal, ongoing process for reevaluating each participating provider within a specified number of years after the provider's initial acceptance for participation. The reevaluation shall include all of the following:

SECTION 3741mmr. 609.32 (2) (c) of the statutes is amended to read:

609.32 **(2)** (c) A ~~managed care~~ defined network plan may not require a participating provider to provide services that are outside the scope of his or her license or certificate.

SECTION 3741mmt. 609.34 of the statutes is renumbered 609.34 (1) and amended to read:

609.34 **(1)** A ~~managed care~~ defined network plan that is not a preferred provider plan shall appoint a physician as medical director. The medical director shall be responsible for clinical protocols, quality assurance activities, and utilization management policies of the plan.

SECTION 3741mmx. 609.34 (2) of the statutes is created to read:

609.34 **(2)** A preferred provider plan may contract for services related to clinical protocols and utilization management. A preferred provider plan or its designee is required to appoint a medical director only to the extent that the preferred provider plan or its designee assumes direct responsibility for clinical protocols and utilization management policies of the plan. The medical director, who shall be a physician, shall be responsible for such protocols and policies of the plan.

SECTION 3741mmy. 609.35 of the statutes is created to read:

609.35 Applicability of requirements to preferred provider plans. Notwithstanding ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to the requirements under ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1).

SECTION 3741mmz. 609.36 (1) (a) (intro.) of the statutes is amended to read:

609.36 **(1)** (a) (intro.) A ~~managed care~~ defined network plan shall provide to the commissioner information related to all of the following:

SECTION 3741nmg. 609.36 (2) of the statutes is amended to read:

609.36 **(2)** CONFIDENTIALITY. A ~~managed care~~ defined network plan shall establish written policies and procedures, consistent with ss. 51.30, 146.82, and 252.15, for the handling of medical records and enrollee communications to ensure confidentiality.

SECTION 3741nmp. 609.38 of the statutes is amended to read:

609.38 Oversight. The office shall perform examinations of insurers that issue ~~managed care~~ defined network plans consistent with ss. 601.43 and 601.44. The commissioner shall by rule develop standards for ~~managed care~~ defined network plans for compliance with the requirements under this chapter.

SECTION 3741nmt. 609.65 (1) (intro.) of the statutes is amended to read:

609.65 **(1)** (intro.) If an enrollee of a limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is examined, evaluated, or treated for a nervous or mental disorder pursuant to an emergency detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m) or (4r) or ch. 980, then, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) to (4) and 609.05 (3), the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan shall do all of the following:

SECTION 3741omg. 609.65 (1) (a) of the statutes is amended to read:

609.65 **(1)** (a) If the provider performing the examination, evaluation, or treatment has a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the

provision of that service to the enrollee, make the service available to the enrollee in accordance with the terms of the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan and the provider agreement.

SECTION 3741omp. 609.65 (1) (b) (intro.) of the statutes is amended to read:

609.65 **(1)** (b) (intro.) If the provider performing the examination, evaluation or treatment does not have a provider agreement with the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan which covers the provision of that service to the enrollee, reimburse the provider for the examination, evaluation, or treatment of the enrollee in an amount not to exceed the maximum reimbursement for the service under the medical assistance program under subch. IV of ch. 49, if any of the following applies:

SECTION 3741omt. 609.65 (1) (b) 1. of the statutes is amended to read:

609.65 **(1)** (b) 1. The service is provided pursuant to a commitment or a court order, except that reimbursement is not required under this subdivision if the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan could have provided the service through a provider with whom it has a provider agreement.

SECTION 3741pmg. 609.65 (1) (b) 2. of the statutes is amended to read:

609.65 **(1)** (b) 2. The service is provided pursuant to an emergency detention under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20 and the provider notifies the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan within 72 hours after the initial provision of the service.

SECTION 3741pmp. 609.65 (2) of the statutes is amended to read:

609.65 **(2)** If after receiving notice under sub. (1) (b) 2. the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan arranges for services to be provided by a provider with whom it has a provider agreement, the limited service health organization, preferred provider plan, or ~~managed care~~ plan is not required to reimburse a provider under sub. (1) (b) 2. for any services provided after arrangements are made under this subsection.

SECTION 3741pmt. 609.65 (3) of the statutes is amended to read:

609.65 **(3)** A limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan is only required to make available, or make reimbursement for, an examination, evaluation, or treatment under sub. (1) to the extent that the limited service health organization, preferred provider plan, or ~~managed care~~ defined network plan would have made the medically necessary service available to the enrollee or reimbursed the provider for the service if any referrals required under s. 609.05 (3) had been made and the service had been performed by a participating provider.

SECTION 3741qmg. 609.655 (1) (a) 1. of the statutes is amended to read:

609.655 **(1)** (a) 1. Is covered as a dependent child under the terms of a policy or certificate issued by a ~~managed care~~ defined network plan insurer.

SECTION 3741qmp. 609.655 (1) (a) 2. of the statutes is amended to read:

609.655 **(1)** (a) 2. Is enrolled in a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741qmt. 609.655 (2) of the statutes is amended to read:

609.655 **(2)** If a policy or certificate issued by a ~~managed care~~ defined network plan insurer provides coverage of outpatient services provided to a dependent student, the policy or certificate shall provide coverage of outpatient services, to the

extent and in the manner required under sub. (3), that are provided to the dependent student while he or she is attending a school located in this state but outside the geographical service area of the ~~managed care~~ defined network plan, notwithstanding the limitations regarding participating providers, primary providers, and referrals under ss. 609.01 (2) and 609.05 (3).

SECTION 3741rmg. 609.655 (3) (intro.) of the statutes is amended to read:

609.655 **(3)** (intro.) Except as provided in sub. (5), a ~~managed care~~ defined network plan shall provide coverage for all of the following services:

SECTION 3741rmp. 609.655 (3) (a) of the statutes is amended to read:

609.655 **(3)** (a) A clinical assessment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems, conducted by a provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and who may be designated by the ~~managed care~~ defined network plan.

SECTION 3741smg. 609.655 (3) (b) (intro.) of the statutes is amended to read:

609.655 **(3)** (b) (intro.) If outpatient services are recommended in the clinical assessment conducted under par. (a), the recommended outpatient services consisting of not more than 5 visits to an outpatient treatment facility or other provider that is located in this state and in reasonably close proximity to the school in which the dependent student is enrolled and that may be designated by the ~~managed care~~ defined network plan, except as follows:

SECTION 3741smp. 609.655 (3) (b) 1. of the statutes is amended to read:

609.655 **(3)** (b) 1. Coverage is not required under this paragraph if the medical director of the ~~managed care~~ defined network plan determines that the nature of the

treatment recommended in the clinical assessment will prohibit the dependent student from attending school on a regular basis.

SECTION 3741smt. 609.655 (4) (a) of the statutes is amended to read:

609.655 **(4)** (a) Upon completion of the 5 visits for outpatient services covered under sub. (3) (b), the medical director of the ~~managed care~~ defined network plan and the clinician treating the dependent student shall review the dependent student's condition and determine whether it is appropriate to continue treatment of the dependent student's nervous or mental disorders or alcoholism or other drug abuse problems in reasonably close proximity to the school in which the student is enrolled. The review is not required if the dependent student is no longer enrolled in the school or if the coverage limits under the policy or certificate for treatment of nervous or mental disorders or alcoholism or other drug abuse problems have been exhausted.

SECTION 3741tmg. 609.655 (4) (b) of the statutes is amended to read:

609.655 **(4)** (b) Upon completion of the review under par. (a), the medical director of the ~~managed care~~ defined network plan shall determine whether the policy or certificate will provide coverage of any further treatment for the dependent student's nervous or mental disorder or alcoholism or other drug abuse problems that is provided by a provider located in reasonably close proximity to the school in which the student is enrolled. If the dependent student disputes the medical director's determination, the dependent student may submit a written grievance under the ~~managed care~~ defined network plan's internal grievance procedure established under s. 632.83.

SECTION 3741tmp. 609.655 (5) (a) of the statutes is amended to read:

609.655 **(5)** (a) A policy or certificate issued by a ~~managed care~~ defined network plan insurer is required to provide coverage for the services specified in sub. (3) only

to the extent that the policy or certificate would have covered the service if it had been provided to the dependent student by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741tmt. 609.655 (5) (b) of the statutes is amended to read:

609.655 **(5)** (b) Paragraph (a) does not permit a ~~managed care~~ defined network plan to reimburse a provider for less than the full cost of the services provided or an amount negotiated with the provider, solely because the reimbursement rate for the service would have been less if provided by a participating provider within the geographical service area of the ~~managed care~~ defined network plan.

SECTION 3741umg. 609.70 of the statutes is amended to read:

609.70 Chiropractic coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.87 (3).

SECTION 3741ump. 609.75 of the statutes is amended to read:

609.75 Adopted children coverage. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.896. Coverage of health care services obtained by adopted children and children placed for adoption may be subject to any requirements that the limited service health organization, preferred provider plan, or managed care defined network plan imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained by other enrollees.

SECTION 3741umt. 609.77 of the statutes is amended to read:

609.77 Coverage of breast reconstruction. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (13).

SECTION 3741vmg. 609.78 of the statutes is amended to read:

609.78 Coverage of treatment for the correction of temporomandibular disorders. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (11).

SECTION 3741vmp. 609.79 of the statutes is amended to read:

609.79 Coverage of hospital and ambulatory surgery center charges and anesthetics for dental care. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895 (12).

SECTION 3741vmt. 609.80 of the statutes is amended to read:

609.80 Coverage of mammograms. ~~Managed care~~ Defined network plans are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be subject to any requirements that the ~~managed care~~ defined network plan imposes under s. 609.05 (2) and (3) on the coverage of other health care services obtained by enrollees.

SECTION 3741wmg. 609.81 of the statutes is amended to read:

609.81 Coverage related to HIV infection. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.93. ~~Managed care~~ Defined network plans are subject to s. 632.895 (9).

SECTION 3741wmp. 609.82 of the statutes is amended to read:

609.82 Coverage without prior authorization for emergency medical condition treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.85.

SECTION 3741wmt. 609.83 of the statutes is amended to read:

609.83 Coverage of drugs and devices. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.853.

SECTION 3741xmg. 609.84 of the statutes is amended to read:

609.84 Experimental treatment. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 632.855.

SECTION 3741xmp. 609.88 of the statutes is amended to read:

609.88 Coverage of immunizations. ~~Managed care~~ Defined network plans are subject to s. 632.895 (14).

SECTION 3741xmr. 609.89 of the statutes is amended to read:

609.89 Written reason for coverage denial. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.17.

SECTION 3741xmt. 609.90 of the statutes is amended to read:

609.90 Restrictions related to domestic abuse. Limited service health organizations, preferred provider plans, and ~~managed care~~ defined network plans are subject to s. 631.95.".

3. Page 1181, line 12: after that line insert:

"**SECTION 3763f.** 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. This paragraph applies to a ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3c)~~ (1b), only

with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

SECTION 3763g. 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 ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3e)~~ (1b).".

(END)