

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

Drafter: kahlepj

May Contact:

Addl. Drafters:

Subject: Insurance - health

Extra Copies:

Submit via email: NO

Requester's email:

Pre Topic:

ARC:.....Hughes - AM66,

Topic:

Preferred provider plans

Instructions:

See Attached

Drafting History:

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Typed</u>	<u>Proofed</u>	<u>Submitted</u>	<u>Jacketed</u>	<u>Required</u>
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/1			rschluet 06/25/2001	_____	lrb_docadmin 06/25/2001		
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	kahlepj 06/28/2001	csicilia 06/28/2001		_____			
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14 ijs 6/27/01

KJL 6/28

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KJL 6/28
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/2	kahlepj 06/25/2001	csicilia 06/26/2001	jfrantze 06/26/2001		lrb_docadmin 06/26/2001		

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Handwritten signatures and dates: J 6/26, BT 6/26

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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Legislator 4 Withdrawn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

Friday, June 22, 2001



State of Wisconsin
2001 - 2002 LEGISLATURE

LRBb1515/1

PJK:/.....

gjs

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
↑

- 1
- 2
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- 4
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At the locations indicated, amend the ~~bill~~ as follows:

1. Page ⁵³⁴ ~~7~~, line ²³ ~~8~~: after that line insert:

" SECTION ~~40~~ ^{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.

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 ~~8~~: after that line insert:

SECTION ~~40~~ ^{1398s} 40.51 (13) of the statutes is amended to read:

1 40.51 (13) Every ~~managed care~~ defined network plan, as defined in s. 609.01
 2 (~~3e~~) (1b), and every limited service health organization, as defined in s. 609.01 (3),
 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).

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

5 "SECTION ~~3~~. Chapter 609 (title) of the statutes is amended to read:

6 CHAPTER 609

7 MANAGED CARE DEFINED NETWORK PLANS

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

9 609.01 (1d) "Enrollee" means, with respect to a ~~managed care~~ defined network
 10 plan, preferred provider plan, or limited service health organization, a person who
 11 is entitled to receive health care services under the plan.

12 SECTION ~~2~~. 609.01 (3c) of the statutes is renumbered 609.01 (1b) and amended
 13 to read:

14 609.01 (1b) "~~Managed care~~ Defined network plan" means a health benefit plan
 15 that requires an enrollee of the health benefit plan, or creates incentives, including
 16 financial incentives, for an enrollee of the health benefit plan, to use providers that
 17 are managed, owned, under contract with, or employed by the insurer offering the
 18 health benefit plan.

19 SECTION ~~2~~. 609.01 (3m) of the statutes is amended to read:

20 609.01 (3m) "Participating" means, with respect to a physician or other
 21 provider, under contract with a ~~managed care~~ defined network plan, preferred
 22 provider plan, or limited service health organization to provide health care services,

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

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

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

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

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

11 **SECTION 3741 b m p** 609.01 (5) of the statutes is amended to read:

12 609.01 (5) "Primary provider" means a participating primary care physician,
13 or other participating provider authorized by the ~~managed-care~~ defined network
14 plan, preferred provider plan, or limited service health organization to serve as a
15 primary provider, who coordinates and may provide ongoing care to an enrollee.

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

16 **SECTION 3741 b m t** 609.05 (1) of the statutes is amended to read:

17 609.05 (1) Except as provided in subs. (2) and (3), a limited service health
18 organization, preferred provider plan, or ~~managed-care~~ defined network plan shall
19 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.

20 **SECTION 3741 c m g** 609.05 (2) of the statutes is amended to read:

21 609.05 (2) Subject to s. 609.22 (4) and (4m), a limited service health
22 organization, preferred provider plan, or ~~managed-care~~ defined network plan may

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

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

3741 cmp

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

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

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

3741 cmt

9 SECTION ~~6~~. 609.17 of the statutes is amended to read:

10 609.17 Reports of disciplinary action. Every limited service health
11 organization, preferred provider plan, and ~~managed-care~~ defined network plan shall
12 notify the medical examining board or appropriate affiliated credentialing board
13 attached to the medical examining board of any disciplinary action taken against a
14 participating provider who holds a license or certificate granted by the board or
15 affiliated credentialing board.

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

3741 dmg

16 SECTION ~~6~~. 609.20 (title) of the statutes is amended to read:

17 609.20 (title) Rules for preferred provider and ~~managed-care~~ defined
18 network plans.

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

3741 dmp

19 SECTION ~~6~~. 609.20 (intro.) of the statutes is renumbered 609.20 (1m) (intro.)

20 and amended to read:

21 609.20 (1m) (intro.) The commissioner shall promulgate rules relating to
22 preferred provider plans and ~~managed-care~~ defined network plans for all of the
23 following purposes:

1 SECTION ~~2~~ ^{3741dmt} 609.20 (1) of the statutes is renumbered 609.20 (1m) (a). ✓

2 SECTION ~~3~~ ^{3741emg} 609.20 (2) of the statutes is renumbered 609.20 (1m) (b). ✓

3 SECTION ~~4~~ ^{3741emp} 609.20 (2m) of the statutes is created to read:
4 609.20 (2m) Any rule promulgated under this chapter shall recognize the
5 differences between preferred provider plans and other types of defined network
6 plans, take into account the fact that preferred provider plans provide coverage for
7 the services of nonparticipating providers, and be appropriate to the type of plan to
8 which the rule applies.

9 SECTION ~~5~~ ^{3741emt} 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act 9, is
10 renumbered 609.20 (1m) (c). ✓

11 SECTION ~~6~~ ^{3741fmg} 609.20 (4) of the statutes, as affected by 2001 Wisconsin Act 9, is
12 renumbered 609.20 (1m) (d). ✓

13 SECTION ~~7~~ ^{3741fmp} 609.22 (1) of the statutes is amended to read:
14 609.22 (1) PROVIDERS. A ~~managed care~~ defined network plan shall include a
15 sufficient number, and sufficient types, of qualified providers that are appropriate
16 to the type of plan to meet the anticipated needs of its enrollees, with respect to
17 covered benefits and normal practices and standards in the geographic area.

18 History: 1997 a. 237; 1999 a. 9. SECTION ~~8~~ ^{3741fmt} 609.22 (2) of the statutes is amended to read: ✓
19 609.22 (2) ADEQUATE CHOICE. A ~~managed care~~ defined network plan that is not
20 a preferred provider plan shall ensure that, with respect to covered benefits, each
21 enrollee has adequate choice among participating providers and that the providers
22 are accessible and qualified.

23 History: 1997 a. 237; 1999 a. 9. SECTION ~~9~~ ^{3741gmg} 609.22 (3) of the statutes is amended to read: ✓

1 609.22 (3) PRIMARY PROVIDER SELECTION. A ~~managed-care~~ defined network plan
2 that is not a preferred provider plan shall permit each enrollee to select his or her
3 own primary provider from a list of participating primary care physicians and any
4 other participating providers that are authorized by the ~~managed-care~~ defined
5 network plan to serve as primary providers. The list shall be updated on an ongoing
6 basis and shall include a sufficient number of primary care physicians and any other
7 participating providers authorized by the plan to serve as primary providers who are
8 accepting new enrollees.

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

9 SECTION ~~3~~ ^{3741 gmp}. 609.22 (4) (a) 1. of the statutes is amended to read:

10 609.22 (4) (a) 1. If a ~~managed-care~~ defined network plan that is not a preferred
11 provider plan requires a referral to a specialist for coverage of specialist services, the
12 ~~managed-care~~ defined network plan that is not a preferred provider plan shall
13 establish a procedure by which an enrollee may apply for a standing referral to a
14 specialist. The procedure must specify the criteria and conditions that must be met
15 in order for an enrollee to obtain a standing referral.

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

16 SECTION ~~3~~ ^{3741 gmt}. 609.22 (4) (a) 2. of the statutes is amended to read:

17 609.22 (4) (a) 2. A ~~managed-care~~ defined network plan that is not a preferred
18 provider plan may require the enrollee's primary provider to remain responsible for
19 coordinating the care of an enrollee who receives a standing referral to a specialist.
20 A ~~managed-care~~ defined network plan that is not a preferred provider plan may
21 restrict the specialist from making any secondary referrals without prior approval
22 by the enrollee's primary provider. If an enrollee requests primary care services from
23 a specialist to whom the enrollee has a standing referral, the specialist, in agreement
24 with the enrollee and the enrollee's primary provider, may provide primary care

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

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

3 SECTION ~~2~~ ^{3741 hmg} 609.22 (4) (a) 3. of the statutes is amended to read:

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

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

8 SECTION ~~2~~ ^{3741 hmp} 609.22 (4m) (a) of the statutes is amended to read:

9 609.22 (4m) (a) A managed-care defined network plan that provides coverage
10 of obstetric or gynecologic services may not require a female enrollee of the managed
11 care defined network plan to obtain a referral for covered obstetric or gynecologic
12 benefits provided by a participating provider who is a physician licensed under ch.
13 448 and who specializes in obstetrics and gynecology, regardless of whether the
14 participating provider is the enrollee's primary provider. Notwithstanding sub. (4),
15 the ~~managed-care~~ defined network plan may not require the enrollee to obtain a
16 standing referral under the procedure established under sub. (4) (a) for covered
17 obstetric or gynecologic benefits.

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

18 SECTION ~~2~~ ^{3741 hmt} 609.22 (4m) (b) (intro.) of the statutes is amended to read:

19 609.22 (4m) (b) (intro.) A managed-care defined network plan under par. (a)
20 may not do any of the following:

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

21 SECTION ~~2~~ ^{3741 mg} 609.22 (4m) (c) of the statutes is amended to read:

1 609.22 (4m) (c) A ~~managed-care~~ defined network plan under par. (a) shall
2 provide written notice of the requirement under par. (a) in every policy or group
3 certificate issued by the ~~managed-care~~ defined network plan.

4 History: 1997 a. 237; 1999 a. 9. *374imp*
SECTION ~~2~~. 609.22 (5) of the statutes is amended to read:

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

8 History: 1997 a. 237; 1999 a. 9. *374imt*
SECTION ~~2~~. 609.22 (6) (intro.) of the statutes is amended to read:

9 609.22 (6) EMERGENCY CARE. (intro.) Notwithstanding s. 632.85, if a ~~managed~~
10 ~~care~~ defined network plan provides coverage of emergency services, with respect to
11 covered benefits, the ~~managed-care~~ defined network plan shall do all of the following:

12 History: 1997 a. 237; 1999 a. 9. *374img*
SECTION ~~2~~. 609.22 (7) of the statutes is amended to read:

13 609.22 (7) TELEPHONE ACCESS. A ~~managed care~~ dcfined network plan that is not
14 a preferred provider plan shall provide telephone access for sufficient time during
15 business and evening hours to ensure that enrollees have adequate access to routine
16 health care services for which coverage is provided under the plan. A ~~managed-care~~
17 defined network plan that is not a preferred provider plan shall provide 24-hour
18 telephone access to the plan or to a participating provider for emergency care, or
19 authorization for care, for which coverage is provided under the plan.

20 History: 1997 a. 237; 1999 a. 9. *374img*
SECTION ~~2~~. 609.22 (8) of the statutes is amended to read:

21 609.22 (8) ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed-care~~ defined
22 network plan shall develop an access plan to meet the needs, with respect to covered
23 benefits, of its enrollees who are members of underserved populations. If a

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

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

4

SECTION ~~2~~. 609.24 (1) (a) (intro.) of the statutes is amended to read:

→ 3741 jmt

5 609.24 (1) (a) (intro.) Subject to pars. (b) and (c) and except as provided in par.
6 (d), a ~~managed-care~~ defined network plan shall, with respect to covered benefits,
7 provide coverage to an enrollee for the services of a provider, regardless of whether
8 the provider is a participating provider at the time the services are provided, if the
9 ~~managed-care~~ defined network plan represented that the provider was, or would be,
10 a participating provider in marketing materials that were provided or available to
11 the enrollee at any of the following times:

History: 1997 a. 237.

12

SECTION ~~2~~. 609.24 (1) (b) (intro.) of the statutes is amended to read:

→ 3741 kmg

13 609.24 (1) (b) (intro.) Except as provided in par. (d), a ~~managed-care~~ defined
14 network plan shall provide the coverage required under par. (a) with respect to the
15 services of a provider who is a primary care physician for the following period of time:

History: 1997 a. 237.

16

SECTION ~~2~~. 609.24 (1) (c) (intro.) of the statutes is amended to read:

→ 3741 kmp

17 609.24 (1) (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing
18 a course of treatment with a participating provider who is not a primary care
19 physician and whose participation with the plan terminates, the ~~managed-care~~
20 defined network plan shall provide the coverage under par. (a) with respect to the
21 services of the provider for the following period of time:

History: 1997 a. 237.

22

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

→ 3741 kmt

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

History: 1997 a. 237.

3741Lmg

3 ~~SECTION 3.~~ 609.24 (1) (d) 2. of the statutes is amended to read:

4 609.24 (1) (d) 2. The insurer issuing the managed-care defined network plan
5 terminates or terminated the provider's contract for misconduct on the part of the
6 provider.

History: 1997 a. 237.

3741Lmp

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

8 609.24 (1) (e) 1. An insurer issuing a managed-care defined network plan shall
9 include in its provider contracts provisions addressing reimbursement to providers
10 for services rendered under this section.

History: 1997 a. 237.

3741Lmt

11 ~~SECTION 3.~~ 609.24 (1) (e) 2. of the statutes is amended to read:

12 609.24 (1) (e) 2. If a contract between a managed-care defined network plan and
13 a provider does not address reimbursement for services rendered under this section,
14 the insurer shall reimburse the provider according to the most recent contracted
15 rate.

History: 1997 a. 237.

3741mmb

16 ~~SECTION 3.~~ 609.24 (4) of the statutes is created to read:

17 609.24 (4) NOTICE OF PROVISIONS. A defined network plan shall notify all plan
18 enrollees of the provisions under this section whenever a participating provider's
19 participation with the plan terminates, or shall, by contract, require a participating
20 provider to notify all plan enrollees of the provisions under this section if the
21 participating provider's participation with the plan terminates.

3741mmd

22 ~~SECTION 3.~~ 609.30 (1) of the statutes is amended to read:

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

History: 1997 a. 237.

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

6 609.30 (2) PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may
7 discuss, with or on behalf of an enrollee, all treatment options and any other
8 information that the provider determines to be in the best interest of the enrollee.
9 A ~~managed-care~~ defined network plan may not penalize or terminate the contract of
10 a participating provider because the provider makes referrals to other participating
11 providers or discusses medically necessary or appropriate care with or on behalf of
12 an enrollee.

History: 1997 a. 237.

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

14 609.32 (1) STANDARDS; OTHER THAN PREFERRED PROVIDER PLANS. (intro.) A
15 ~~managed-care~~ defined network plan that is not a preferred provider plan shall
16 develop comprehensive quality assurance standards that are adequate to identify,
17 evaluate, and remedy problems related to access to, and continuity and quality of,
18 care. The standards shall include at least all of the following:

History: 1997 a. 237.

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

20 609.32 (1m) PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A
21 preferred provider plan shall develop procedures for remedying quality of care
22 problems, including written procedures for taking appropriate corrective action.

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

1 609.32 (2) (a) A ~~managed-care~~ defined network plan shall develop a process for
2 selecting participating providers, including written policies and procedures that the
3 plan uses for review and approval of providers. After consulting with appropriately
4 qualified providers, the plan shall establish minimum professional requirements for
5 its participating providers. The process for selection shall include verification of a
6 provider's license or certificate, including the history of any suspensions or
7 revocations, and the history of any liability claims made against the provider.

History: 1997 a. 237.

8 SECTION ~~22~~ ^{3741 mm p}. 609.32 (2) (b) (intro.) of the statutes is amended to read:

9 609.32 (2) (b) (intro.) A ~~managed-care~~ defined network plan shall establish in
10 writing a formal, ongoing process for reevaluating each participating provider
11 within a specified number of years after the provider's initial acceptance for
12 participation. The reevaluation shall include all of the following:

History: 1997 a. 237.

13 SECTION ~~22~~ ^{3741 mm r}. 609.32 (2) (c) of the statutes is amended to read:

14 609.32 (2) (c) A ~~managed-care~~ defined network plan may not require a
15 participating provider to provide services that are outside the scope of his or her
16 license or certificate.

History: 1997 a. 237.

17 SECTION ~~22~~ ^{3741 mm t}. 609.34 of the statutes is renumbered 609.34 (1) and amended to
18 read:

19 609.34 (1) A ~~managed-care~~ defined network plan shall appoint a physician as
20 medical director. The medical director shall be responsible for clinical protocols,
21 quality assurance activities, and utilization management policies of the plan.

History: 1997 a. 237.

22 SECTION ~~22~~ ^{3741 mm x}. 609.34 (2) of the statutes is created to read:

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

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

9 609.36 (1) (a) (intro.) A ~~managed-care~~ defined network plan shall provide to the
10 commissioner information related to all of the following:

History: 1997 a. 237.

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

12 609.36 (2) CONFIDENTIALITY. A ~~managed-care~~ defined network plan shall
13 establish written policies and procedures, consistent with ss. 51.30, 146.82, and
14 252.15, for the handling of medical records and enrollee communications to ensure
15 confidentiality.

History: 1997 a. 237.

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

17 **609.38 Oversight.** The office shall perform examinations of insurers that
18 issue ~~managed-care~~ defined network plans consistent with ss. 601.43 and 601.44.
19 The commissioner shall by rule develop standards for ~~managed-care~~ defined network
20 plans for compliance with the requirements under this chapter.

History: 1997 a. 237.

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

22 609.65 (1) (intro.) If an enrollee of a limited service health organization,
23 preferred provider plan, or ~~managed-care~~ defined network plan is examined,
24 evaluated, or treated for a nervous or mental disorder pursuant to an emergency

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

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237. 37410mg

6 SECTION ~~37~~. 609.65 (1) (a) of the statutes is amended to read:

7 609.65 (1) (a) If the provider performing the examination, evaluation, or
 8 treatment has a provider agreement with the limited service health organization,
 9 preferred provider plan, or ~~managed care~~ defined network plan which covers the
 10 provision of that service to the enrollee, make the service available to the enrollee in
 11 accordance with the terms of the limited service health organization, preferred
 12 provider plan, or ~~managed care~~ defined network plan and the provider agreement.

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237. 37410mp

13 SECTION ~~37~~. 609.65 (1) (b) (intro.) of the statutes is amended to read:

14 609.65 (1) (b) (intro.) If the provider performing the examination, evaluation
 15 or treatment does not have a provider agreement with the limited service health
 16 organization, preferred provider plan, or ~~managed care~~ defined network plan which
 17 covers the provision of that service to the enrollee, reimburse the provider for the
 18 examination, evaluation, or treatment of the enrollee in an amount not to exceed the
 19 maximum reimbursement for the service under the medical assistance program
 20 under subch. IV of ch. 49, if any of the following applies:

History: 1987 a. 366; 1993 a. 316, 479; 1995 a. 27; 1997 a. 237. 37410mt

21 SECTION ~~37~~. 609.65 (1) (b) 1. of the statutes is amended to read:

22 609.65 (1) (b) 1. The service is provided pursuant to a commitment or a court
 23 order, except that reimbursement is not required under this subdivision if the limited
 24 service health organization, preferred provider plan, or ~~managed care~~ defined

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

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

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

4 609.65 (1) (b) 2. The service is provided pursuant to an emergency detention
5 under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20
6 and the provider notifies the limited service health organization, preferred provider
7 plan, or ~~managed-care~~ defined network plan within 72 hours after the initial
8 provision of the service. 3741 pmp

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

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

10 609.65 (2) If after receiving notice under sub. (1) (b) 2. the limited service health
11 organization, preferred provider plan, or ~~managed-care~~ defined network plan
12 arranges for services to be provided by a provider with whom it has a provider
13 agreement, the limited service health organization, preferred provider plan, or
14 ~~managed-care~~ plan is not required to reimburse a provider under sub. (1) (b) 2. for
15 any services provided after arrangements are made under this subsection.

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

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

17 609.65 (3) A limited service health organization, preferred provider plan, or
18 ~~managed-care~~ defined network plan is only required to make available, or make
19 reimbursement for, an examination, evaluation, or treatment under sub. (1) to the
20 extent that the limited service health organization, preferred provider plan, or
21 ~~managed-care~~ defined network plan would have made the medically necessary
22 service available to the enrollee or reimbursed the provider for the service if any

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

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

3741gmg

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

4 609.655 (1) (a) 1. Is covered as a dependent child under the terms of a policy
5 or certificate issued by a ~~managed care~~ defined network plan insurer.

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

3741gmp

6 SECTION ~~27~~. 609.655 (1) (a) 2. of the statutes is amended to read:

7 609.655 (1) (a) 2. Is enrolled in a school located in this state but outside the
8 geographical service area of the ~~managed care~~ defined network plan.

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

3741gmt

9 SECTION ~~27~~. 609.655 (2) of the statutes is amended to read:

10 609.655 (2) If a policy or certificate issued by a ~~managed care~~ defined network
11 plan insurer provides coverage of outpatient services provided to a dependent
12 student, the policy or certificate shall provide coverage of outpatient services, to the
13 extent and in the manner required under sub. (3), that are provided to the dependent
14 student while he or she is attending a school located in this state but outside the
15 geographical service area of the ~~managed care~~ defined network plan,
16 notwithstanding the limitations regarding participating providers, primary
17 providers, and referrals under ss. 609.01 (2) and 609.05 (3).

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

3741rmg

18 SECTION ~~27~~. 609.655 (3) (intro.) of the statutes is amended to read:

19 609.655 (3) (intro.) Except as provided in sub. (5), a ~~managed care~~ defined
20 network plan shall provide coverage for all of the following services:

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

3741rmp

21 SECTION ~~27~~. 609.655 (3) (a) of the statutes is amended to read:

22 609.655 (3) (a) A clinical assessment of the dependent student's nervous or
23 mental disorders or alcoholism or other drug abuse problems, conducted by a

1 provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in
2 reasonably close proximity to the school in which the dependent student is enrolled
3 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

4 SECTION ~~2.~~ 609.655 (3) (b) (intro.) of the statutes is amended to read:

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

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

3741smp

11 SECTION ~~2.~~ 609.655 (3) (b) 1. of the statutes is amended to read:

12 609.655 (3) (b) 1. Coverage is not required under this paragraph if the medical
13 director of the ~~managed-care~~ defined network plan determines that the nature of the
14 treatment recommended in the clinical assessment will prohibit the dependent
15 student from attending school on a regular basis.

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

3741smt

16 SECTION ~~2.~~ 609.655 (4) (a) of the statutes is amended to read:

17 609.655 (4) (a) Upon completion of the 5 visits for outpatient services covered
18 under sub. (3) (b), the medical director of the ~~managed-care~~ defined network plan and
19 the clinician treating the dependent student shall review the dependent student's
20 condition and determine whether it is appropriate to continue treatment of the
21 dependent student's nervous or mental disorders or alcoholism or other drug abuse
22 problems in reasonably close proximity to the school in which the student is enrolled.
23 The review is not required if the dependent student is no longer enrolled in the school

1 or if the coverage limits under the policy or certificate for treatment of nervous or
2 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.

3 **SECTION 609.655 (4) (b)** of the statutes is amended to read:

3741mg

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

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

13 **SECTION 609.655 (5) (a)** of the statutes is amended to read:

3741mp

14 609.655 (5) (a) A policy or certificate issued by a ~~managed-care~~ defined network
15 plan insurer is required to provide coverage for the services specified in sub. (3) only
16 to the extent that the policy or certificate would have covered the service if it had been
17 provided to the dependent student by a participating provider within the
18 geographical service area of the ~~managed-care~~ defined network plan.

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

19 **SECTION 609.655 (5) (b)** of the statutes is amended to read:

3741mt

20 609.655 (5) (b) Paragraph (a) does not permit a ~~managed-care~~ defined network
21 plan to reimburse a provider for less than the full cost of the services provided or an
22 amount negotiated with the provider, solely because the reimbursement rate for the

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

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

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

4 **609.70 Chiropractic coverage.** Limited service health organizations,
5 preferred provider plans, and ~~managed care defined network~~ plans are subject to s.
6 632.87 (3).

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

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

8 **609.75 Adopted children coverage.** Limited service health organizations,
9 preferred provider plans, and ~~managed care defined network~~ plans are subject to s.
10 632.896. Coverage of health care services obtained by adopted children and children
11 placed for adoption may be subject to any requirements that the limited service
12 health organization, preferred provider plan, or ~~managed care defined network~~ plan
13 imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained
14 by other enrollees.

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

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

16 **609.77 Coverage of breast reconstruction.** Limited service health
17 organizations, preferred provider plans, and ~~managed care defined network~~ plans
18 are subject to s. 632.895 (13).

History: 1997 a. 27, 237.

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

20 **609.78 Coverage of treatment for the correction of**
21 **temporomandibular disorders.** Limited service health organizations, preferred
22 provider plans, and ~~managed care defined network~~ plans are subject to s. 632.895
23 (11).

History: 1997 a. 27, 237.

3741vmp

1

SECTION ~~27~~. 609.79 of the statutes is amended to read:

2 **609.79 Coverage of hospital and ambulatory surgery center charges**
3 **and anesthetics for dental care.** Limited service health organizations, preferred
4 provider plans, and ~~managed-care~~ defined network plans are subject to s. 632.895
5 (12).

History: 1997 a. 27, 237.

3741vmt

6

SECTION ~~27~~. 609.80 of the statutes is amended to read:

7 **609.80 Coverage of mammograms.** ~~Managed-care~~ Defined network plans
8 are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be
9 subject to any requirements that the ~~managed-care~~ defined network plan imposes
10 under s. 609.05 (2) and (3) on the coverage of other health care services obtained by
11 enrollees.

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

3741wmg

12

SECTION ~~27~~. 609.81 of the statutes is amended to read:

13 **609.81 Coverage related to HIV infection.** Limited service health
14 organizations, preferred provider plans, and ~~managed-care~~ defined network plans
15 are subject to s. 631.93. ~~Managed-care~~ Defined network plans are subject to s.
16 632.895 (9).

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

3741wmp

17

SECTION ~~27~~. 609.82 of the statutes is amended to read:

18 **609.82 Coverage without prior authorization for emergency medical**
19 **condition treatment.** Limited service health organizations, preferred provider
20 plans, and ~~managed-care~~ defined network plans are subject to s. 632.85.

History: 1997 a. 237.

3741wmt

21

SECTION ~~27~~. 609.83 of the statutes is amended to read:

1 **609.83 Coverage of drugs and devices.** Limited service health
2 organizations, preferred provider plans, and ~~managed-care~~ defined network plans
3 are subject to s. 632.853.

History: 1997 a. 237.

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

5 **609.84 Experimental treatment.** Limited service health organizations,
6 preferred provider plans, and ~~managed-care~~ defined network plans are subject to s.
7 632.855.

History: 1997 a. 237.

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

9 **609.88 Coverage of immunizations.** ~~Managed-care~~ Defined network plans
10 are subject to s. 632.895 (14).

History: 1999 a. 115.

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

12 **609.89 Written reason for coverage denial.** Limited service health
13 organizations, preferred provider plans, and ~~managed-care~~ defined network plans
14 are subject to s. 631.17.

History: 1999 a. 95.

15 **4.** Page 1, line 12: after that line insert:

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

17 632.895 (14) (c) The coverage required under par. (b) may not be subject to any
18 deductibles, copayments, or coinsurance under the policy or plan. This paragraph
19 applies to a ~~managed-care~~ defined network plan, as defined in s. 609.01 (3e) (1b), only
20 with respect to appropriate and necessary immunizations provided by providers
21 participating, as defined in s. 609.01 (3m), in the plan.

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 66, 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.

22 **SECTION 3763g.** 632.895 (14) (d) 3. of the statutes is amended to read:

Insert 21-14

1 632.895 (14) (d) 3. A health care plan offered by a limited service health
 2 organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined
 3 in s. 609.01 (4), that is not a ~~managed-care~~ defined network plan, as defined in s.
 4 609.01 (~~3e~~) (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, 113; 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 networks


(and of ins 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), 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



missouri
stays

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

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

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

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

4 40.51 (12) Every managed-care defined network plan, as defined in s. 609.01
5 (3e) (1b), and every limited service health organization, as defined in s. 609.01 (3),
6 that is offered by the state under sub. (6) shall comply with ch. 609.

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

8 40.51 (13) Every managed-care defined network plan, as defined in s. 609.01
9 (3e) (1b), and every limited service health organization, as defined in s. 609.01 (3),

1 that is offered by the group insurance board under sub. (7) shall comply with ch.
2 609.”.

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

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

5 **CHAPTER 609**

6 **MANAGED CARE DEFINED NETWORK PLANS**

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

8 609.01 (1d) “Enrollee” means, with respect to a ~~managed care~~ defined network
9 plan, preferred provider plan, or limited service health organization, a person who
10 is entitled to receive health care services under the plan.

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

13 609.01 (1b) “~~Managed care~~ Defined network plan” means a health benefit plan
14 that requires an enrollee of the health benefit plan, or creates incentives, including
15 financial incentives, for an enrollee of the health benefit plan, to use providers that
16 are managed, owned, under contract with, or employed by the insurer offering the
17 health benefit plan.

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

19 609.01 (3m) “Participating” means, with respect to a physician or other
20 provider, under contract with a ~~managed care~~ defined network plan, preferred
21 provider plan, or limited service health organization to provide health care services,
22 items or supplies to enrollees of the ~~managed care~~ defined network plan, preferred
23 provider plan, or limited service health organization.

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

2 609.01 (4) "Preferred provider plan" means a health care plan offered by an
3 organization established under ch. 185, 611, 613, or 614 or issued a certificate of
4 authority under ch. 618 that makes available to its enrollees, without referral and
5 for consideration other than predetermined periodic fixed payments, coverage of
6 either comprehensive health care services or a limited range of health care services,
7 regardless of whether the health care services are performed by participating or
8 nonparticipating providers participating in the plan.

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

10 609.01 (5) "Primary provider" means a participating primary care physician,
11 or other participating provider authorized by the ~~managed care~~ defined network
12 plan, preferred provider plan, or limited service health organization to serve as a
13 primary provider, who coordinates and may provide ongoing care to an enrollee.

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

15 609.05 (1) Except as provided in subs. (2) and (3), a limited service health
16 organization, preferred provider plan, or ~~managed care~~ defined network plan shall
17 permit its enrollees to choose freely among participating providers.

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

19 609.05 (2) Subject to s. 609.22 (4) and (4m), a limited service health
20 organization, preferred provider plan, or ~~managed care~~ defined network plan may
21 require an enrollee to designate a primary provider and to obtain health care services
22 from the primary provider when reasonably possible.

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

24 609.05 (3) Except as provided in ss. 609.22 (4m), 609.65, and 609.655, a limited
25 service health organization, preferred provider plan, or ~~managed care~~ defined

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

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

5 **609.17 Reports of disciplinary action.** Every limited service health
6 organization, preferred provider plan, and ~~managed care~~ defined network plan shall
7 notify the medical examining board or appropriate affiliated credentialing board
8 attached to the medical examining board of any disciplinary action taken against a
9 participating provider who holds a license or certificate granted by the board or
10 affiliated credentialing board.

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

12 **609.20 (title) Rules for preferred provider and ~~managed care~~ defined**
13 **network plans.**

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

16 609.20 (1m) (intro.) The commissioner shall promulgate rules relating to
17 preferred provider plans and ~~managed care~~ defined network plans for all of the
18 following purposes:

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

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

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

22 609.20 (2m) Any rule promulgated under this chapter shall recognize the
23 differences between preferred provider plans and other types of defined network
24 plans, take into account the fact that preferred provider plans provide coverage for

as appropriate to the type of plan

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

3 SECTION 3741emt. 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act
4 9, is renumbered 609.20 (1m) (c).

5 SECTION 3741fmg. 609.20 (4) of the statutes, as affected by 2001 Wisconsin Act
6 9, is renumbered 609.20 (1m) (d).

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

8 609.22 (1) PROVIDERS. A ~~managed-care~~ defined network plan shall include a
9 sufficient number, and sufficient types, of qualified providers ~~and sufficient types~~

10 ~~of the type of plan~~ to meet the anticipated needs of its enrollees, with respect to
11 covered benefits and normal practices and standards in the geographic area.

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

13 609.22 (2) ADEQUATE CHOICE. A ~~managed-care~~ defined network plan that is not
14 a preferred provider plan shall ensure that, with respect to covered benefits, each
15 enrollee has adequate choice among participating providers and that the providers
16 are accessible and qualified.

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

18 609.22 (3) PRIMARY PROVIDER SELECTION. A ~~managed-care~~ defined network plan
19 that is not a preferred provider plan shall permit each enrollee to select his or her
20 own primary provider from a list of participating primary care physicians and any
21 other participating providers that are authorized by the ~~managed-care~~ defined
22 network plan to serve as primary providers. The list shall be updated on an ongoing
23 basis and shall include a sufficient number of primary care physicians and any other
24 participating providers authorized by the plan to serve as primary providers who are
25 accepting new enrollees.

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

2 609.22 (4) (a) 1. If a ~~managed care~~ defined network plan that is not a preferred
3 provider plan requires a referral to a specialist for coverage of specialist services, the
4 ~~managed care~~ defined network plan that is not a preferred provider plan shall
5 establish a procedure by which an enrollee may apply for a standing referral to a
6 specialist. The procedure must specify the criteria and conditions that must be met
7 in order for an enrollee to obtain a standing referral.

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

9 609.22 (4) (a) 2. A ~~managed care~~ defined network plan that is not a preferred
10 provider plan may require the enrollee's primary provider to remain responsible for
11 coordinating the care of an enrollee who receives a standing referral to a specialist.
12 A ~~managed care~~ defined network plan that is not a preferred provider plan may
13 restrict the specialist from making any secondary referrals without prior approval
14 by the enrollee's primary provider. If an enrollee requests primary care services from
15 a specialist to whom the enrollee has a standing referral, the specialist, in agreement
16 with the enrollee and the enrollee's primary provider, may provide primary care
17 services to the enrollee in accordance with procedures established by the ~~managed~~
18 ~~care~~ defined network plan that is not a preferred provider plan.

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

20 609.22 (4) (a) 3. A ~~managed care~~ defined network plan that is not a preferred
21 provider plan must include information regarding referral procedures in policies or
22 certificates provided to enrollees and must provide such information to an enrollee
23 or prospective enrollee upon request.

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

1 609.22 (4m) (a) A ~~managed-care~~ defined network plan that provides coverage
2 of obstetric or gynecologic services may not require a female enrollee of the ~~managed~~
3 ~~care~~ defined network plan to obtain a referral for covered obstetric or gynecologic
4 benefits provided by a participating provider who is a physician licensed under ch.
5 448 and who specializes in obstetrics and gynecology, regardless of whether the
6 participating provider is the enrollee's primary provider. Notwithstanding sub. (4),
7 the ~~managed-care~~ defined network plan may not require the enrollee to obtain a
8 standing referral under the procedure established under sub. (4) (a) for covered
9 obstetric or gynecologic benefits.

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

11 609.22 (4m) (b) (intro.) A ~~managed-care~~ defined network plan under par. (a)
12 may not do any of the following:

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

14 609.22 (4m) (c) A ~~managed-care~~ defined network plan under par. (a) shall
15 provide written notice of the requirement under par. (a) in every policy or group
16 certificate issued by the ~~managed-care~~ defined network plan.

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

18 609.22 (5) SECOND OPINIONS. A ~~managed-care~~ defined network plan shall
19 provide an enrollee with coverage for a 2nd opinion from another participating
20 provider.

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

22 609.22 (6) EMERGENCY CARE. (intro.) Notwithstanding s. 632.85, if a ~~managed~~
23 ~~care~~ defined network plan provides coverage of emergency services, with respect to
24 covered benefits, the ~~managed-care~~ defined network plan shall do all of the following:

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

1 609.22 (7) TELEPHONE ACCESS. A ~~managed care~~ defined network plan that is not
2 a preferred provider plan shall provide telephone access for sufficient time during
3 business and evening hours to ensure that enrollees have adequate access to routine
4 health care services for which coverage is provided under the plan. A ~~managed care~~
5 defined network plan that is not a preferred provider plan shall provide 24-hour
6 telephone access to the plan or to a participating provider for emergency care, or
7 authorization for care, for which coverage is provided under the plan.

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

9 609.22 (8) ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed care~~ defined
10 network plan shall develop an access plan to meet the needs, with respect to covered
11 benefits, of its enrollees who are members of underserved populations. If a
12 significant number of enrollees of the plan customarily use languages other than
13 English, the ~~managed care~~ defined network plan shall provide access to translation
14 services fluent in those languages to the greatest extent possible.

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

16 609.24 (1) (a) (intro.) Subject to pars. (b) and (c) and except as provided in par.
17 (d), a ~~managed care~~ defined network plan shall, with respect to covered benefits,
18 provide coverage to an enrollee for the services of a provider, regardless of whether
19 the provider is a participating provider at the time the services are provided, if the
20 ~~managed care~~ defined network plan represented that the provider was, or would be,
21 a participating provider in marketing materials that were provided or available to
22 the enrollee at any of the following times:

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

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

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

5 609.24 (1) (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing
6 a course of treatment with a participating provider who is not a primary care
7 physician and whose participation with the plan terminates, the managed-care
8 defined network plan shall provide the coverage under par. (a) with respect to the
9 services of the provider for the following period of time:

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

11 609.24 (1) (d) 1. The provider no longer practices in the managed-care defined
12 network plan's geographic service area.

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

14 609.24 (1) (d) 2. The insurer issuing the managed-care defined network plan
15 terminates or terminated the provider's contract for misconduct on the part of the
16 provider.

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

18 609.24 (1) (e) 1. An insurer issuing a managed-care defined network plan shall
19 include in its provider contracts provisions addressing reimbursement to providers
20 for services rendered under this section.

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

22 609.24 (1) (e) 2. If a contract between a managed-care defined network plan and
23 a provider does not address reimbursement for services rendered under this section,
24 the insurer shall reimburse the provider according to the most recent contracted
25 rate.

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

2 609.24 (4) NOTICE OF PROVISIONS. A defined network plan shall notify all plan
3 enrollees of the provisions under this section whenever a participating provider's
4 participation with the plan terminates, or shall, by contract, require a participating
5 provider to notify all plan enrollees of the provisions under this section if the
6 participating provider's participation with the plan terminates.

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

8 609.30 (1) PLAN MAY NOT CONTRACT. A ~~managed care~~ defined network plan may
9 not contract with a participating provider to limit the provider's disclosure of
10 information, to or on behalf of an enrollee, about the enrollee's medical condition or
11 treatment options.

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

13 609.30 (2) PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may
14 discuss, with or on behalf of an enrollee, all treatment options and any other
15 information that the provider determines to be in the best interest of the enrollee.
16 A ~~managed care~~ defined network plan may not penalize or terminate the contract of
17 a participating provider because the provider makes referrals to other participating
18 providers or discusses medically necessary or appropriate care with or on behalf of
19 an enrollee.

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

21 609.32 (1) STANDARDS; OTHER THAN PREFERRED PROVIDER PLANS. (intro.) A
22 ~~managed care~~ defined network plan that is not a preferred provider plan shall
23 develop comprehensive quality assurance standards that are adequate to identify,
24 evaluate, and remedy problems related to access to, and continuity and quality of,
25 care. The standards shall include at least all of the following:

remedial action to address

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

2 609.32 (1m) PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A
3 preferred provider plan shall develop ^a procedures ^e for ~~remedial~~ quality of care
4 problems, including written procedures for taking appropriate corrective action.

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

6 609.32 (2) (a) A ~~managed care~~ defined network plan shall develop a process for
7 selecting participating providers, including written policies and procedures that the
8 plan uses for review and approval of providers. After consulting with appropriately
9 qualified providers, the plan shall establish minimum professional requirements for
10 its participating providers. The process for selection shall include verification of a
11 provider's license or certificate, including the history of any suspensions or
12 revocations, and the history of any liability claims made against the provider.

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

14 609.32 (2) (b) (intro.) A ~~managed care~~ defined network plan shall establish in
15 writing a formal, ongoing process for reevaluating each participating provider
16 within a specified number of years after the provider's initial acceptance for
17 participation. The reevaluation shall include all of the following:

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

19 609.32 (2) (c) A ~~managed care~~ defined network plan may not require a
20 participating provider to provide services that are outside the scope of his or her
21 license or certificate.

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

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

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

5 609.34 (2) Notwithstanding sub. (1), a preferred provider plan may contract for
6 services related to clinical protocols and utilization management. A preferred
7 provider plan or its designee is required to appoint a medical director only to the
8 extent that the preferred provider plan or its designee assumes direct responsibility
9 for clinical protocols and utilization management policies of the plan. The medical
10 director, who shall be a physician, shall be responsible for such protocols and policies
11 of the plan.

Insert 12-11 ✓

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

13 609.36 (1) (a) (intro.) A ~~managed-care~~ defined network plan shall provide to the
14 commissioner information related to all of the following:

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

16 609.36 (2) **CONFIDENTIALITY.** A ~~managed-care~~ defined network plan shall
17 establish written policies and procedures, consistent with ss. 51.30, 146.82, and
18 252.15, for the handling of medical records and enrollee communications to ensure
19 confidentiality.

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

21 **609.38 Oversight.** The office shall perform examinations of insurers that
22 issue ~~managed-care~~ defined network plans consistent with ss. 601.43 and 601.44.
23 The commissioner shall by rule develop standards for ~~managed-care~~ defined network
24 plans for compliance with the requirements under this chapter.

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

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

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

10 609.65 (1) (a) If the provider performing the examination, evaluation, or
11 treatment has a provider agreement with the limited service health organization,
12 preferred provider plan, or ~~managed-care~~ defined network plan which covers the
13 provision of that service to the enrollee, make the service available to the enrollee in
14 accordance with the terms of the limited service health organization, preferred
15 provider plan, or ~~managed-care~~ defined network plan and the provider agreement.

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

17 609.65 (1) (b) (intro.) If the provider performing the examination, evaluation
18 or treatment does not have a provider agreement with the limited service health
19 organization, preferred provider plan, or ~~managed-care~~ defined network plan which
20 covers the provision of that service to the enrollee, reimburse the provider for the
21 examination, evaluation, or treatment of the enrollee in an amount not to exceed the
22 maximum reimbursement for the service under the medical assistance program
23 under subch. IV of ch. 49, if any of the following applies:

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

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

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

7 609.65 (1) (b) 2. The service is provided pursuant to an emergency detention
8 under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20
9 and the provider notifies the limited service health organization, preferred provider
10 plan, or ~~managed-care~~ defined network plan within 72 hours after the initial
11 provision of the service.

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

13 609.65 (2) If after receiving notice under sub. (1) (b) 2. the limited service health
14 organization, preferred provider plan, or ~~managed-care~~ defined network plan
15 arranges for services to be provided by a provider with whom it has a provider
16 agreement, the limited service health organization, preferred provider plan, or
17 ~~managed-care~~ plan is not required to reimburse a provider under sub. (1) (b) 2. for
18 any services provided after arrangements are made under this subsection.

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

20 609.65 (3) A limited service health organization, preferred provider plan, or
21 ~~managed-care~~ defined network plan is only required to make available, or make
22 reimbursement for, an examination, evaluation, or treatment under sub. (1) to the
23 extent that the limited service health organization, preferred provider plan, or
24 ~~managed-care~~ defined network plan would have made the medically necessary
25 service available to the enrollee or reimbursed the provider for the service if any

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

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

4 609.655 (1) (a) 1. Is covered as a dependent child under the terms of a policy
5 or certificate issued by a ~~managed-care~~ defined network plan insurer.

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

7 609.655 (1) (a) 2. Is enrolled in a school located in this state but outside the
8 geographical service area of the ~~managed-care~~ defined network plan.

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

10 609.655 (2) If a policy or certificate issued by a ~~managed-care~~ defined network
11 plan insurer provides coverage of outpatient services provided to a dependent
12 student, the policy or certificate shall provide coverage of outpatient services, to the
13 extent and in the manner required under sub. (3), that are provided to the dependent
14 student while he or she is attending a school located in this state but outside the
15 geographical service area of the ~~managed-care~~ defined network plan,
16 notwithstanding the limitations regarding participating providers, primary
17 providers, and referrals under ss. 609.01 (2) and 609.05 (3).

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

19 609.655 (3) (intro.) Except as provided in sub. (5), a ~~managed-care~~ defined
20 network plan shall provide coverage for all of the following services:

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

22 609.655 (3) (a) A clinical assessment of the dependent student's nervous or
23 mental disorders or alcoholism or other drug abuse problems, conducted by a
24 provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in

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

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

4 609.655 (3) (b) (intro.) If outpatient services are recommended in the clinical
5 assessment conducted under par. (a), the recommended outpatient services
6 consisting of not more than 5 visits to an outpatient treatment facility or other
7 provider that is located in this state and in reasonably close proximity to the school
8 in which the dependent student is enrolled and that may be designated by the
9 ~~managed care~~ defined network plan, except as follows:

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

11 609.655 (3) (b) 1. Coverage is not required under this paragraph if the medical
12 director of the ~~managed care~~ defined network plan determines that the nature of the
13 treatment recommended in the clinical assessment will prohibit the dependent
14 student from attending school on a regular basis.

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

16 609.655 (4) (a) Upon completion of the 5 visits for outpatient services covered
17 under sub. (3) (b), the medical director of the ~~managed care~~ defined network plan and
18 the clinician treating the dependent student shall review the dependent student's
19 condition and determine whether it is appropriate to continue treatment of the
20 dependent student's nervous or mental disorders or alcoholism or other drug abuse
21 problems in reasonably close proximity to the school in which the student is enrolled.
22 The review is not required if the dependent student is no longer enrolled in the school
23 or if the coverage limits under the policy or certificate for treatment of nervous or
24 mental disorders or alcoholism or other drug abuse problems have been exhausted.

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

1 609.655 (4) (b) Upon completion of the review under par. (a), the medical
2 director of the ~~managed-care~~ defined network plan shall determine whether the
3 policy or certificate will provide coverage of any further treatment for the dependent
4 student's nervous or mental disorder or alcoholism or other drug abuse problems that
5 is provided by a provider located in reasonably close proximity to the school in which
6 the student is enrolled. If the dependent student disputes the medical director's
7 determination, the dependent student may submit a written grievance under the
8 ~~managed-care~~ defined network plan's internal grievance procedure established
9 under s. 632.83.

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

11 609.655 (5) (a) A policy or certificate issued by a ~~managed-care~~ defined network
12 plan insurer is required to provide coverage for the services specified in sub. (3) only
13 to the extent that the policy or certificate would have covered the service if it had been
14 provided to the dependent student by a participating provider within the
15 geographical service area of the ~~managed-care~~ defined network plan.

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

17 609.655 (5) (b) Paragraph (a) does not permit a ~~managed-care~~ defined network
18 plan to reimburse a provider for less than the full cost of the services provided or an
19 amount negotiated with the provider, solely because the reimbursement rate for the
20 service would have been less if provided by a participating provider within the
21 geographical service area of the ~~managed-care~~ defined network plan.

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

23 **609.70 Chiropractic coverage.** Limited service health organizations,
24 preferred provider plans, and ~~managed-care~~ defined network plans are subject to s.
25 632.87 (3).

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

2 **609.75 Adopted children coverage.** Limited service health organizations,
3 preferred provider plans, and ~~managed-care~~ defined network plans are subject to s.
4 632.896. Coverage of health care services obtained by adopted children and children
5 placed for adoption may be subject to any requirements that the limited service
6 health organization, preferred provider plan, or ~~managed-care~~ defined network plan
7 imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained
8 by other enrollees.

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

10 **609.77 Coverage of breast reconstruction.** Limited service health
11 organizations, preferred provider plans, and ~~managed-care~~ defined network plans
12 are subject to s. 632.895 (13).

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

14 **609.78 Coverage of treatment for the correction of**
15 **temporomandibular disorders.** Limited service health organizations, preferred
16 provider plans, and ~~managed-care~~ defined network plans are subject to s. 632.895
17 (11).

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

19 **609.79 Coverage of hospital and ambulatory surgery center charges**
20 **and anesthetics for dental care.** Limited service health organizations, preferred
21 provider plans, and ~~managed-care~~ defined network plans are subject to s. 632.895
22 (12).

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

24 **609.80 Coverage of mammograms.** ~~Managed-care~~ Defined network plans
25 are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be

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

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

5 **609.81 Coverage related to HIV infection.** Limited service health
6 organizations, preferred provider plans, and ~~managed-care~~ defined network plans
7 are subject to s. 631.93. ~~Managed-care~~ Defined network plans are subject to s.
8 632.895 (9).

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

10 **609.82 Coverage without prior authorization for emergency medical**
11 **condition treatment.** Limited service health organizations, preferred provider
12 plans, and ~~managed-care~~ defined network plans are subject to s. 632.85.

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

14 **609.83 Coverage of drugs and devices.** Limited service health
15 organizations, preferred provider plans, and ~~managed-care~~ defined network plans
16 are subject to s. 632.853.

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

18 **609.84 Experimental treatment.** Limited service health organizations,
19 preferred provider plans, and ~~managed-care~~ defined network plans are subject to s.
20 632.855.

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

22 **609.88 Coverage of immunizations.** ~~Managed-care~~ Defined network plans
23 are subject to s. 632.895 (14).

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

1 **609.89 Written reason for coverage denial.** Limited service health
2 organizations, preferred provider plans, and ~~managed-care~~ defined network plans
3 are subject to s. 631.17.

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

5 **609.90 Restrictions related to domestic abuse.** Limited service health
6 organizations, preferred provider plans, and ~~managed-care~~ defined network plans
7 are subject to s. 631.95.”.

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

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

10 632.895 (14) (c) The coverage required under par. (b) may not be subject to any
11 deductibles, copayments, or coinsurance under the policy or plan. This paragraph
12 applies to a ~~managed-care~~ defined network plan, as defined in s. 609.01 (~~3e~~) (1b), only
13 with respect to appropriate and necessary immunizations provided by providers
14 participating, as defined in s. 609.01 (3m), in the plan.

15 **SECTION 3763g.** 632.895 (14) (d) 3. of the statutes is amended to read:

16 632.895 (14) (d) 3. A health care plan offered by a limited service health
17 organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined
18 in s. 609.01 (4), that is not a ~~managed-care~~ defined network plan, as defined in s.
19 609.01 (~~3e~~) (1b).”.

20

(END)

2001-2002 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBb1515/lins
PJK:cjs:rs

INSERT 12-11

1 SECTION 3741[^]mm. 609.35 of the statutes is created to read:

2 **609.35 Applicability of requirements to preferred provider plans.**

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

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

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

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

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

4 40.51 (12) Every ~~managed care~~ defined network plan, as defined in s. 609.01

5 (3e) (1b), and every limited service health organization, as defined in s. 609.01 (3),

6 that is offered by the state under sub. (6) shall comply with ch. 609.

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

8 40.51 (13) Every ~~managed care~~ defined network plan, as defined in s. 609.01

9 (3e) (1b), and every limited service health organization, as defined in s. 609.01 (3),

1 that is offered by the group insurance board under sub. (7) shall comply with ch.
2 609.”.

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

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

5 **CHAPTER 609**

6 **MANAGED-CARE DEFINED NETWORK PLANS**

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

8 609.01 (1d) “Enrollee” means, with respect to a ~~managed-care~~ defined network
9 plan, preferred provider plan, or limited service health organization, a person who
10 is entitled to receive health care services under the plan.

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

13 609.01 (1b) “~~Managed-care~~ Defined network plan” means a health benefit plan
14 that requires an enrollee of the health benefit plan, or creates incentives, including
15 financial incentives, for an enrollee of the health benefit plan, to use providers that
16 are managed, owned, under contract with, or employed by the insurer offering the
17 health benefit plan.

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

19 609.01 (3m) “Participating” means, with respect to a physician or other
20 provider, under contract with a ~~managed-care~~ defined network plan, preferred
21 provider plan, or limited service health organization to provide health care services,
22 items or supplies to enrollees of the ~~managed-care~~ defined network plan, preferred
23 provider plan, or limited service health organization.

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

2 609.01 (4) “Preferred provider plan” means a health care plan offered by an
3 organization established under ch. 185, 611, 613, or 614 or issued a certificate of
4 authority under ch. 618 that makes available to its enrollees, without referral and
5 for consideration other than predetermined periodic fixed payments, coverage of
6 either comprehensive health care services or a limited range of health care services,
7 regardless of whether the health care services are performed by participating or
8 nonparticipating providers participating in the plan.

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

10 609.01 (5) “Primary provider” means a participating primary care physician,
11 or other participating provider authorized by the ~~managed care~~ defined network
12 plan, preferred provider plan, or limited service health organization to serve as a
13 primary provider, who coordinates and may provide ongoing care to an enrollee.

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

15 609.05 (1) Except as provided in subs. (2) and (3), a limited service health
16 organization, preferred provider plan, or ~~managed care~~ defined network plan shall
17 permit its enrollees to choose freely among participating providers.

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

19 609.05 (2) Subject to s. 609.22 (4) and (4m), a limited service health
20 organization, preferred provider plan, or ~~managed care~~ defined network plan may
21 require an enrollee to designate a primary provider and to obtain health care services
22 from the primary provider when reasonably possible.

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

24 609.05 (3) Except as provided in ss. 609.22 (4m), 609.65, and 609.655, a limited
25 service health organization, preferred provider plan, or ~~managed care~~ defined

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

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

5 **609.17 Reports of disciplinary action.** Every limited service health
6 organization, preferred provider plan, and ~~managed care~~ defined network plan shall
7 notify the medical examining board or appropriate affiliated credentialing board
8 attached to the medical examining board of any disciplinary action taken against a
9 participating provider who holds a license or certificate granted by the board or
10 affiliated credentialing board.

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

12 **609.20 (title) Rules for preferred provider and ~~managed care~~ defined**
13 **network plans.**

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

16 609.20 (1m) (intro.) The commissioner shall promulgate rules relating to
17 preferred provider plans and ~~managed care~~ defined network plans for all of the
18 following purposes:

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

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

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

22 609.20 (2m) Any rule promulgated under this chapter shall recognize the
23 differences between preferred provider plans and other types of defined network
24 plans, take into account the fact that preferred provider plans provide coverage for

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

3 **SECTION 3741emt.** 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act
4 9, is renumbered 609.20 (1m) (c).

5 **SECTION 3741fmg.** 609.20 (4) of the statutes, as affected by 2001 Wisconsin Act
6 9, is renumbered 609.20 (1m) (d).

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

8 609.22 (1) PROVIDERS. A ~~managed care~~ defined network plan shall include a
9 sufficient number, and sufficient types, of qualified providers to meet the anticipated
10 needs of its enrollees, with respect to covered benefits, as appropriate to the type of
11 plan and consistent with normal practices and standards in the geographic area.

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

13 609.22 (2) ADEQUATE CHOICE. A ~~managed care~~ defined network plan that is not
14 a preferred provider plan shall ensure that, with respect to covered benefits, each
15 enrollee has adequate choice among participating providers and that the providers
16 are accessible and qualified.

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

18 609.22 (3) PRIMARY PROVIDER SELECTION. A ~~managed care~~ defined network plan
19 that is not a preferred provider plan shall permit each enrollee to select his or her
20 own primary provider from a list of participating primary care physicians and any
21 other participating providers that are authorized by the ~~managed care~~ defined
22 network plan to serve as primary providers. The list shall be updated on an ongoing
23 basis and shall include a sufficient number of primary care physicians and any other
24 participating providers authorized by the plan to serve as primary providers who are
25 accepting new enrollees.

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

2 609.22 (4) (a) 1. If a ~~managed care~~ defined network plan that is not a preferred
3 provider plan requires a referral to a specialist for coverage of specialist services, the
4 ~~managed care~~ defined network plan that is not a preferred provider plan shall
5 establish a procedure by which an enrollee may apply for a standing referral to a
6 specialist. The procedure must specify the criteria and conditions that must be met
7 in order for an enrollee to obtain a standing referral.

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

9 609.22 (4) (a) 2. A ~~managed care~~ defined network plan that is not a preferred
10 provider plan may require the enrollee's primary provider to remain responsible for
11 coordinating the care of an enrollee who receives a standing referral to a specialist.
12 A ~~managed care~~ defined network plan that is not a preferred provider plan may
13 restrict the specialist from making any secondary referrals without prior approval
14 by the enrollee's primary provider. If an enrollee requests primary care services from
15 a specialist to whom the enrollee has a standing referral, the specialist, in agreement
16 with the enrollee and the enrollee's primary provider, may provide primary care
17 services to the enrollee in accordance with procedures established by the ~~managed~~
18 ~~care~~ defined network plan that is not a preferred provider plan.

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

20 609.22 (4) (a) 3. A ~~managed care~~ defined network plan that is not a preferred
21 provider plan must include information regarding referral procedures in policies or
22 certificates provided to enrollees and must provide such information to an enrollee
23 or prospective enrollee upon request.

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

1 609.22 (4m) (a) A ~~managed-care~~ defined network plan that provides coverage
2 of obstetric or gynecologic services may not require a female enrollee of the ~~managed~~
3 ~~care~~ defined network plan to obtain a referral for covered obstetric or gynecologic
4 benefits provided by a participating provider who is a physician licensed under ch.
5 448 and who specializes in obstetrics and gynecology, regardless of whether the
6 participating provider is the enrollee's primary provider. Notwithstanding sub. (4),
7 the ~~managed-care~~ defined network plan may not require the enrollee to obtain a
8 standing referral under the procedure established under sub. (4) (a) for covered
9 obstetric or gynecologic benefits.

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

11 609.22 (4m) (b) (intro.) A ~~managed-care~~ defined network plan under par. (a)
12 may not do any of the following:

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

14 609.22 (4m) (c) A ~~managed-care~~ defined network plan under par. (a) shall
15 provide written notice of the requirement under par. (a) in every policy or group
16 certificate issued by the ~~managed-care~~ defined network plan.

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

18 609.22 (5) SECOND OPINIONS. A ~~managed-care~~ defined network plan shall
19 provide an enrollee with coverage for a 2nd opinion from another participating
20 provider.

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

22 609.22 (6) EMERGENCY CARE. (intro.) Notwithstanding s. 632.85, if a ~~managed~~
23 ~~care~~ defined network plan provides coverage of emergency services, with respect to
24 covered benefits, the ~~managed-care~~ defined network plan shall do all of the following:

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

1 609.22 (7) TELEPHONE ACCESS. A ~~managed-care~~ defined network plan that is not
2 a preferred provider plan shall provide telephone access for sufficient time during
3 business and evening hours to ensure that enrollees have adequate access to routine
4 health care services for which coverage is provided under the plan. A ~~managed-care~~
5 defined network plan that is not a preferred provider plan shall provide 24-hour
6 telephone access to the plan or to a participating provider for emergency care, or
7 authorization for care, for which coverage is provided under the plan.

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

9 609.22 (8) ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed-care~~ defined
10 network plan shall develop an access plan to meet the needs, with respect to covered
11 benefits, of its enrollees who are members of underserved populations. If a
12 significant number of enrollees of the plan customarily use languages other than
13 English, the ~~managed-care~~ defined network plan shall provide access to translation
14 services fluent in those languages to the greatest extent possible.

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

16 609.24 (1) (a) (intro.) Subject to pars. (b) and (c) and except as provided in par.
17 (d), a ~~managed-care~~ defined network plan shall, with respect to covered benefits,
18 provide coverage to an enrollee for the services of a provider, regardless of whether
19 the provider is a participating provider at the time the services are provided, if the
20 ~~managed-care~~ defined network plan represented that the provider was, or would be,
21 a participating provider in marketing materials that were provided or available to
22 the enrollee at any of the following times:

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

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

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

5 609.24 (1) (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing
6 a course of treatment with a participating provider who is not a primary care
7 physician and whose participation with the plan terminates, the ~~managed-care~~
8 defined network plan shall provide the coverage under par. (a) with respect to the
9 services of the provider for the following period of time:

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

11 609.24 (1) (d) 1. The provider no longer practices in the ~~managed-care~~ defined
12 network plan's geographic service area.

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

14 609.24 (1) (d) 2. The insurer issuing the ~~managed-care~~ defined network plan
15 terminates or terminated the provider's contract for misconduct on the part of the
16 provider.

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

18 609.24 (1) (e) 1. An insurer issuing a ~~managed-care~~ defined network plan shall
19 include in its provider contracts provisions addressing reimbursement to providers
20 for services rendered under this section.

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

22 609.24 (1) (e) 2. If a contract between a managed care defined network plan and
23 a provider does not address reimbursement for services rendered under this section,
24 the insurer shall reimburse the provider according to the most recent contracted
25 rate.

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

2 609.24 (4) NOTICE OF PROVISIONS. A defined network plan shall notify all plan
3 enrollees of the provisions under this section whenever a participating provider's
4 participation with the plan terminates, or shall, by contract, require a participating
5 provider to notify all plan enrollees of the provisions under this section if the
6 participating provider's participation with the plan terminates.

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

8 609.30 (1) PLAN MAY NOT CONTRACT. A ~~managed care~~ defined network plan may
9 not contract with a participating provider to limit the provider's disclosure of
10 information, to or on behalf of an enrollee, about the enrollee's medical condition or
11 treatment options.

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

13 609.30 (2) PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may
14 discuss, with or on behalf of an enrollee, all treatment options and any other
15 information that the provider determines to be in the best interest of the enrollee.
16 A ~~managed care~~ defined network plan may not penalize or terminate the contract of
17 a participating provider because the provider makes referrals to other participating
18 providers or discusses medically necessary or appropriate care with or on behalf of
19 an enrollee.

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

21 609.32 (1) STANDARDS; OTHER THAN PREFERRED PROVIDER PLANS. (intro.) A
22 ~~managed care~~ defined network plan that is not a preferred provider plan shall
23 develop comprehensive quality assurance standards that are adequate to identify,
24 evaluate, and remedy problems related to access to, and continuity and quality of,
25 care. The standards shall include at least all of the following:

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

2 609.32 (1m) PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A
3 preferred provider plan shall develop a procedure for remedial action to address
4 quality problems, including written procedures for taking appropriate corrective
5 action.

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

7 609.32 (2) (a) A ~~managed-care~~ defined network plan shall develop a process for
8 selecting participating providers, including written policies and procedures that the
9 plan uses for review and approval of providers. After consulting with appropriately
10 qualified providers, the plan shall establish minimum professional requirements for
11 its participating providers. The process for selection shall include verification of a
12 provider's license or certificate, including the history of any suspensions or
13 revocations, and the history of any liability claims made against the provider.

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

15 609.32 (2) (b) (intro.) A ~~managed-care~~ defined network plan shall establish in
16 writing a formal, ongoing process for reevaluating each participating provider
17 within a specified number of years after the provider's initial acceptance for
18 participation. The reevaluation shall include all of the following:

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

20 609.32 (2) (c) A ~~managed-care~~ defined network plan may not require a
21 participating provider to provide services that are outside the scope of his or her
22 license or certificate.

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

that is not a preferred provider plan

1

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.

4

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

5

609.34 (2) ~~Notwithstanding ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (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.

12

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

13

609.35 Applicability of requirements to preferred provider plans.

14

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

17

609.34 (1).

the requirements under

19

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

20

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

22

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

23

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

24

1 252.15, for the handling of medical records and enrollee communications to ensure
2 confidentiality.

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

4 **609.38 Oversight.** The office shall perform examinations of insurers that
5 issue ~~managed-care~~ defined network plans consistent with ss. 601.43 and 601.44.
6 The commissioner shall by rule develop standards for ~~managed-care~~ defined network
7 plans for compliance with the requirements under this chapter.

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

9 609.65 (1) (intro.) If an enrollee of a limited service health organization,
10 preferred provider plan, or ~~managed-care~~ defined network plan is examined,
11 evaluated, or treated for a nervous or mental disorder pursuant to an emergency
12 detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m)
13 or (4r) or ch. 980, then, notwithstanding the limitations regarding participating
14 providers, primary providers, and referrals under ss. 609.01 (2) to (4) and 609.05 (3),
15 the limited service health organization, preferred provider plan, or ~~managed-care~~
16 defined network plan shall do all of the following:

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

18 609.65 (1) (a) If the provider performing the examination, evaluation, or
19 treatment has a provider agreement with the limited service health organization,
20 preferred provider plan, or ~~managed-care~~ defined network plan which covers the
21 provision of that service to the enrollee, make the service available to the enrollee in
22 accordance with the terms of the limited service health organization, preferred
23 provider plan, or ~~managed-care~~ defined network plan and the provider agreement.

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

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

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

9 609.65 (1) (b) 1. The service is provided pursuant to a commitment or a court
10 order, except that reimbursement is not required under this subdivision if the limited
11 service health organization, preferred provider plan, or ~~managed-care~~ defined
12 network plan could have provided the service through a provider with whom it has
13 a provider agreement.

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

15 609.65 (1) (b) 2. The service is provided pursuant to an emergency detention
16 under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20
17 and the provider notifies the limited service health organization, preferred provider
18 plan, or ~~managed-care~~ defined network plan within 72 hours after the initial
19 provision of the service.

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

21 609.65 (2) If after receiving notice under sub. (1) (b) 2. the limited service health
22 organization, preferred provider plan, or ~~managed-care~~ defined network plan
23 arranges for services to be provided by a provider with whom it has a provider
24 agreement, the limited service health organization, preferred provider plan, or

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

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

4 609.65 (3) A limited service health organization, preferred provider plan, or
5 ~~managed care defined network~~ plan is only required to make available, or make
6 reimbursement for, an examination, evaluation, or treatment under sub. (1) to the
7 extent that the limited service health organization, preferred provider plan, or
8 ~~managed care defined network~~ plan would have made the medically necessary
9 service available to the enrollee or reimbursed the provider for the service if any
10 referrals required under s. 609.05 (3) had been made and the service had been
11 performed by a participating provider.

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

13 609.655 (1) (a) 1. Is covered as a dependent child under the terms of a policy
14 or certificate issued by a ~~managed care defined network~~ plan insurer.

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

16 609.655 (1) (a) 2. Is enrolled in a school located in this state but outside the
17 geographical service area of the ~~managed care defined network~~ plan.

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

19 609.655 (2) If a policy or certificate issued by a ~~managed care defined network~~
20 plan insurer provides coverage of outpatient services provided to a dependent
21 student, the policy or certificate shall provide coverage of outpatient services, to the
22 extent and in the manner required under sub. (3), that are provided to the dependent
23 student while he or she is attending a school located in this state but outside the
24 geographical service area of the ~~managed care defined network~~ plan.

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

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

4 609.655 (3) (intro.) Except as provided in sub. (5), a ~~managed-care~~ defined
5 network plan shall provide coverage for all of the following services:

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

7 609.655 (3) (a) A clinical assessment of the dependent student's nervous or
8 mental disorders or alcoholism or other drug abuse problems, conducted by a
9 provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in
10 reasonably close proximity to the school in which the dependent student is enrolled
11 and who may be designated by the ~~managed-care~~ defined network plan.

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

13 609.655 (3) (b) (intro.) If outpatient services are recommended in the clinical
14 assessment conducted under par. (a), the recommended outpatient services
15 consisting of not more than 5 visits to an outpatient treatment facility or other
16 provider that is located in this state and in reasonably close proximity to the school
17 in which the dependent student is enrolled and that may be designated by the
18 ~~managed-care~~ defined network plan, except as follows:

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

20 609.655 (3) (b) 1. Coverage is not required under this paragraph if the medical
21 director of the ~~managed-care~~ defined network plan determines that the nature of the
22 treatment recommended in the clinical assessment will prohibit the dependent
23 student from attending school on a regular basis.

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

1 609.655 (4) (a) Upon completion of the 5 visits for outpatient services covered
2 under sub. (3) (b), the medical director of the ~~managed care~~ defined network plan and
3 the clinician treating the dependent student shall review the dependent student's
4 condition and determine whether it is appropriate to continue treatment of the
5 dependent student's nervous or mental disorders or alcoholism or other drug abuse
6 problems in reasonably close proximity to the school in which the student is enrolled.
7 The review is not required if the dependent student is no longer enrolled in the school
8 or if the coverage limits under the policy or certificate for treatment of nervous or
9 mental disorders or alcoholism or other drug abuse problems have been exhausted.

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

11 609.655 (4) (b) Upon completion of the review under par. (a), the medical
12 director of the ~~managed care~~ defined network plan shall determine whether the
13 policy or certificate will provide coverage of any further treatment for the dependent
14 student's nervous or mental disorder or alcoholism or other drug abuse problems that
15 is provided by a provider located in reasonably close proximity to the school in which
16 the student is enrolled. If the dependent student disputes the medical director's
17 determination, the dependent student may submit a written grievance under the
18 ~~managed care~~ defined network plan's internal grievance procedure established
19 under s. 632.83.

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

21 609.655 (5) (a) A policy or certificate issued by a ~~managed care~~ defined network
22 plan insurer is required to provide coverage for the services specified in sub. (3) only
23 to the extent that the policy or certificate would have covered the service if it had been
24 provided to the dependent student by a participating provider within the
25 geographical service area of the ~~managed care~~ defined network plan.

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

2 609.655 (5) (b) Paragraph (a) does not permit a ~~managed care~~ defined network
3 plan to reimburse a provider for less than the full cost of the services provided or an
4 amount negotiated with the provider, solely because the reimbursement rate for the
5 service would have been less if provided by a participating provider within the
6 geographical service area of the ~~managed care~~ defined network plan.

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

8 **609.70 Chiropractic coverage.** Limited service health organizations,
9 preferred provider plans, and ~~managed care~~ defined network plans are subject to s.
10 632.87 (3).

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

12 **609.75 Adopted children coverage.** Limited service health organizations,
13 preferred provider plans, and ~~managed care~~ defined network plans are subject to s.
14 632.896. Coverage of health care services obtained by adopted children and children
15 placed for adoption may be subject to any requirements that the limited service
16 health organization, preferred provider plan, or ~~managed care~~ defined network plan
17 imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained
18 by other enrollees.

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

20 **609.77 Coverage of breast reconstruction.** Limited service health
21 organizations, preferred provider plans, and ~~managed care~~ defined network plans
22 are subject to s. 632.895 (13).

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

24 **609.78 Coverage of treatment for the correction of**
25 **temporomandibular disorders.** Limited service health organizations, preferred

1 provider plans, and ~~managed-care~~ defined network plans are subject to s. 632.895
2 (11).

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

4 **609.79 Coverage of hospital and ambulatory surgery center charges**
5 **and anesthetics for dental care.** Limited service health organizations, preferred
6 provider plans, and ~~managed-care~~ defined network plans are subject to s. 632.895
7 (12).

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

9 **609.80 Coverage of mammograms.** ~~Managed-care~~ Defined network plans
10 are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be
11 subject to any requirements that the ~~managed-care~~ defined network plan imposes
12 under s. 609.05 (2) and (3) on the coverage of other health care services obtained by
13 enrollees.

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

15 **609.81 Coverage related to HIV infection.** Limited service health
16 organizations, preferred provider plans, and ~~managed-care~~ defined network plans
17 are subject to s. 631.93. ~~Managed-care~~ Defined network plans are subject to s.
18 632.895 (9).

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

20 **609.82 Coverage without prior authorization for emergency medical**
21 **condition treatment.** Limited service health organizations, preferred provider
22 plans, and ~~managed-care~~ defined network plans are subject to s. 632.85.

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

1 **609.83 Coverage of drugs and devices.** Limited service health
2 organizations, preferred provider plans, and ~~managed care~~ defined network plans
3 are subject to s. 632.853.

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

5 **609.84 Experimental treatment.** Limited service health organizations,
6 preferred provider plans, and ~~managed care~~ defined network plans are subject to s.
7 632.855.

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

9 **609.88 Coverage of immunizations.** ~~Managed care~~ Defined network plans
10 are subject to s. 632.895 (14).

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

12 **609.89 Written reason for coverage denial.** Limited service health
13 organizations, preferred provider plans, and ~~managed care~~ defined network plans
14 are subject to s. 631.17.

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

16 **609.90 Restrictions related to domestic abuse.** Limited service health
17 organizations, preferred provider plans, and ~~managed care~~ defined network plans
18 are subject to s. 631.95.”.

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

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

21 632.895 (14) (c) The coverage required under par. (b) may not be subject to any
22 deductibles, copayments, or coinsurance under the policy or plan. This paragraph
23 applies to a ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3e)~~ (1b), only

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

3 **SECTION 3763g.** 632.895 (14) (d) 3. of the statutes is amended to read:

4 632.895 (14) (d) 3. A health care plan offered by a limited service health
5 organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined
6 in s. 609.01 (4), that is not a ~~managed-care~~ defined network plan, as defined in s.
7 609.01 (~~3e~~) (1b).”

8

(END)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBb1653/3dn
MCG: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 than 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

LRBb1515/4
PJK:cjs:pg

vmis run

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

Note
see p 4 insert

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

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

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

4 40.51 (12) Every ~~managed care~~ defined network plan, as defined in s. 609.01

5 (3e) (1b), and every limited service health organization, as defined in s. 609.01 (3),

6 that is offered by the state under sub. (G) shall comply with ch. 609.

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

8 40.51 (13) Every ~~managed care~~ defined network plan, as defined in s. 609.01

9 (3e) (1b), and every limited service health organization, as defined in s. 609.01 (3),

1 that is offered by the group insurance board under sub. (7) shall comply with ch.
2 609.”.

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

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

5 **CHAPTER 609**

6 **MANAGED CARE DEFINED NETWORK PLANS**

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

8 609.01 (1d) “Enrollee” means, with respect to a ~~managed care~~ defined network
9 plan, preferred provider plan, or limited service health organization, a person who
10 is entitled to receive health care services under the plan.

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

13 609.01 (1b) “~~Managed care~~ Defined network plan” means a health benefit plan
14 that requires an enrollee of the health benefit plan, or creates incentives, including
15 financial incentives, for an enrollee of the health benefit plan, to use providers that
16 are managed, owned, under contract with, or employed by the insurer offering the
17 health benefit plan.

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

19 609.01 (3m) “Participating” means, with respect to a physician or other
20 provider, under contract with a ~~managed care~~ defined network plan, preferred
21 provider plan, or limited service health organization to provide health care services,
22 items or supplies to enrollees of the ~~managed care~~ defined network plan, preferred
23 provider plan, or limited service health organization.

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

2 609.01 (4) “Preferred provider plan” means a health care plan offered by an
3 organization established under ch. 185, 611, 613, or 614 or issued a certificate of
4 authority under ch. 618 that makes available to its enrollees, without referral and
5 for consideration other than predetermined periodic fixed payments, coverage of
6 either comprehensive health care services or a limited range of health care services,
7 regardless of whether the health care services are performed by participating or
8 nonparticipating providers participating in the plan.

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

10 609.01 (5) “Primary provider” means a participating primary care physician,
11 or other participating provider authorized by the ~~managed care~~ defined network
12 plan, preferred provider plan, or limited service health organization to serve as a
13 primary provider, who coordinates and may provide ongoing care to an enrollee.

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

15 609.05 (1) Except as provided in subs. (2) and (3), a limited service health
16 organization, preferred provider plan, or ~~managed care~~ defined network plan shall
17 permit its enrollees to choose freely among participating providers.

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

19 609.05 (2) Subject to s. 609.22 (4) and (4m), a limited service health
20 organization, preferred provider plan, or ~~managed care~~ defined network plan may
21 require an enrollee to designate a primary provider and to obtain health care services
22 from the primary provider when reasonably possible.

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

24 609.05 (3) Except as provided in ss. 609.22 (4m), 609.65, and 609.655, a limited
25 service health organization, preferred provider plan, or ~~managed care~~ defined

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

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

5 **609.17 Reports of disciplinary action.** Every limited service health
6 organization, preferred provider plan, and ~~managed care~~ defined network plan shall
7 notify the medical examining board or appropriate affiliated credentialing board
8 attached to the medical examining board of any disciplinary action taken against a
9 participating provider who holds a license or certificate granted by the board or
10 affiliated credentialing board.

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

12 **609.20 (title) Rules for preferred provider and ~~managed care~~ defined**
13 **network plans.**

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

16 609.20 (1m) (intro.) The commissioner ~~shall~~ ^{may} promulgate rules relating to ^{any}
17 preferred provider plans and ~~managed care~~ defined network plans for ~~all~~ ^{any} of the
18 following purposes: ^{as appropriate}

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

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

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

22 609.20 (2m) Any rule promulgated under this chapter shall recognize the
23 differences between preferred provider plans and other types of defined network
24 plans, take into account the fact that preferred provider plans provide coverage for

Insert 4-3

Handwritten annotations: "strike" with arrows pointing to "shall" and "any" with an arrow pointing to "all". "may" is written above "shall".

Handwritten circles around line numbers 16, 17, and 18.

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

3 **SECTION 3741emt.** 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act
4 9, is renumbered 609.20 (1m) (c).

5 **SECTION 3741fmg.** 609.20 (4) of the statutes, as affected by 2001 Wisconsin Act
6 9, is renumbered 609.20 (1m) (d).

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

8 609.22 (1) PROVIDERS. A ~~managed care~~ defined network plan shall include a
9 sufficient number, and sufficient types, of qualified providers to meet the anticipated
10 needs of its enrollees, with respect to covered benefits, as appropriate to the type of
11 plan and consistent with normal practices and standards in the geographic area.

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

13 609.22 (2) ADEQUATE CHOICE. A ~~managed care~~ defined network plan that is not
14 a preferred provider plan shall ensure that, with respect to covered benefits, each
15 enrollee has adequate choice among participating providers and that the providers
16 are accessible and qualified.

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

18 609.22 (3) PRIMARY PROVIDER SELECTION. A ~~managed care~~ defined network plan
19 that is not a preferred provider plan shall permit each enrollee to select his or her
20 own primary provider from a list of participating primary care physicians and any
21 other participating providers that are authorized by the ~~managed care~~ defined
22 network plan to serve as primary providers. The list shall be updated on an ongoing
23 basis and shall include a sufficient number of primary care physicians and any other
24 participating providers authorized by the plan to serve as primary providers who are
25 accepting new enrollees.

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

2 609.22 (4) (a) 1. If a ~~managed care~~ defined network plan that is not a preferred
3 provider plan requires a referral to a specialist for coverage of specialist services, the
4 ~~managed care~~ defined network plan that is not a preferred provider plan shall
5 establish a procedure by which an enrollee may apply for a standing referral to a
6 specialist. The procedure must specify the criteria and conditions that must be met
7 in order for an enrollee to obtain a standing referral.

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

9 609.22 (4) (a) 2. A ~~managed care~~ defined network plan that is not a preferred
10 provider plan may require the enrollee's primary provider to remain responsible for
11 coordinating the care of an enrollee who receives a standing referral to a specialist.
12 A ~~managed care~~ defined network plan that is not a preferred provider plan may
13 restrict the specialist from making any secondary referrals without prior approval
14 by the enrollee's primary provider. If an enrollee requests primary care services from
15 a specialist to whom the enrollee has a standing referral, the specialist, in agreement
16 with the enrollee and the enrollee's primary provider, may provide primary care
17 services to the enrollee in accordance with procedures established by the ~~managed~~
18 ~~care~~ defined network plan that is not a preferred provider plan.

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

20 609.22 (4) (a) 3. A ~~managed care~~ defined network plan that is not a preferred
21 provider plan must include information regarding referral procedures in policies or
22 certificates provided to enrollees and must provide such information to an enrollee
23 or prospective enrollee upon request.

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

1 609.22 (4m) (a) A ~~managed-care~~ defined network plan that provides coverage
2 of obstetric or gynecologic services may not require a female enrollee of the ~~managed~~
3 ~~care~~ defined network plan to obtain a referral for covered obstetric or gynecologic
4 benefits provided by a participating provider who is a physician licensed under ch.
5 448 and who specializes in obstetrics and gynecology, regardless of whether the
6 participating provider is the enrollee's primary provider. Notwithstanding sub. (4),
7 the ~~managed-care~~ defined network plan may not require the enrollee to obtain a
8 standing referral under the procedure established under sub. (4) (a) for covered
9 obstetric or gynecologic benefits.

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

11 609.22 (4m) (b) (intro.) A ~~managed-care~~ defined network plan under par. (a)
12 may not do any of the following:

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

14 609.22 (4m) (c) A ~~managed-care~~ defined network plan under par. (a) shall
15 provide written notice of the requirement under par. (a) in every policy or group
16 certificate issued by the ~~managed-care~~ defined network plan.

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

18 609.22 (5) SECOND OPINIONS. A ~~managed-care~~ defined network plan shall
19 provide an enrollee with coverage for a 2nd opinion from another participating
20 provider.

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

22 609.22 (6) EMERGENCY CARE. (intro.) Notwithstanding s. 632.85, if a ~~managed~~
23 ~~care~~ defined network plan provides coverage of emergency services, with respect to
24 covered benefits, the ~~managed-care~~ defined network plan shall do all of the following:

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

1 609.22 (7) TELEPHONE ACCESS. A ~~managed-care~~ defined network plan that is not
2 a preferred provider plan shall provide telephone access for sufficient time during
3 business and evening hours to ensure that enrollees have adequate access to routine
4 health care services for which coverage is provided under the plan. A ~~managed-care~~
5 defined network plan that is not a preferred provider plan shall provide 24-hour
6 telephone access to the plan or to a participating provider for emergency care, or
7 authorization for care, for which coverage is provided under the plan.

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

9 609.22 (8) ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed-care~~ defined
10 network plan shall develop an access plan to meet the needs, with respect to covered
11 benefits, of its enrollees who are members of underserved populations. If a
12 significant number of enrollees of the plan customarily use languages other than
13 English, the ~~managed-care~~ defined network plan shall provide access to translation
14 services fluent in those languages to the greatest extent possible.

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

16 609.24 (1) (a) (intro.) Subject to pars. (b) and (c) and except as provided in par.
17 (d), a ~~managed-care~~ defined network plan shall, with respect to covered benefits,
18 provide coverage to an enrollee for the services of a provider, regardless of whether
19 the provider is a participating provider at the time the services are provided, if the
20 ~~managed-care~~ defined network plan represented that the provider was, or would be,
21 a participating provider in marketing materials that were provided or available to
22 the enrollee at any of the following times:

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

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

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

5 609.24 (1) (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing
6 a course of treatment with a participating provider who is not a primary care
7 physician and whose participation with the plan terminates, the ~~managed care~~
8 defined network plan shall provide the coverage under par. (a) with respect to the
9 services of the provider for the following period of time:

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

11 609.24 (1) (d) 1. The provider no longer practices in the ~~managed care~~ defined
12 network plan's geographic service area.

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

14 609.24 (1) (d) 2. The insurer issuing the ~~managed care~~ defined network plan
15 terminates or terminated the provider's contract for misconduct on the part of the
16 provider.

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

18 609.24 (1) (e) 1. An insurer issuing a ~~managed care~~ defined network plan shall
19 include in its provider contracts provisions addressing reimbursement to providers
20 for services rendered under this section.

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

22 609.24 (1) (e) 2. If a contract between a ~~managed care~~ defined network plan and
23 a provider does not address reimbursement for services rendered under this section,
24 the insurer shall reimburse the provider according to the most recent contracted
25 rate.

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

2 609.24 (4) NOTICE OF PROVISIONS. A defined network plan shall notify all plan
3 enrollees of the provisions under this section whenever a participating provider's
4 participation with the plan terminates, or shall, by contract, require a participating
5 provider to notify all plan enrollees of the provisions under this section if the
6 participating provider's participation with the plan terminates.

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

8 609.30 (1) PLAN MAY NOT CONTRACT. A ~~managed care~~ defined network plan may
9 not contract with a participating provider to limit the provider's disclosure of
10 information, to or on behalf of an enrollee, about the enrollee's medical condition or
11 treatment options.

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

13 609.30 (2) PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may
14 discuss, with or on behalf of an enrollee, all treatment options and any other
15 information that the provider determines to be in the best interest of the enrollee.
16 A ~~managed care~~ defined network plan may not penalize or terminate the contract of
17 a participating provider because the provider makes referrals to other participating
18 providers or discusses medically necessary or appropriate care with or on behalf of
19 an enrollee.

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

21 609.32 (1) STANDARDS; OTHER THAN PREFERRED PROVIDER PLANS. (intro.) A
22 ~~managed care defined network~~ plan that is not a preferred provider plan shall
23 develop comprehensive quality assurance standards that are adequate to identify,
24 evaluate, and remedy problems related to access to, and continuity and quality of,
25 care. The standards shall include at least all of the following:

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

2 609.32 (1m) PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A
3 preferred provider plan shall develop a procedure for remedial action to address
4 quality problems, including written procedures for taking appropriate corrective
5 action.

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

7 609.32 (2) (a) A ~~managed care~~ defined network plan shall develop a process for
8 selecting participating providers, including written policies and procedures that the
9 plan uses for review and approval of providers. After consulting with appropriately
10 qualified providers, the plan shall establish minimum professional requirements for
11 its participating providers. The process for selection shall include verification of a
12 provider's license or certificate, including the history of any suspensions or
13 revocations, and the history of any liability claims made against the provider.

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

15 609.32 (2) (b) (intro.) A ~~managed care~~ defined network plan shall establish in
16 writing a formal, ongoing process for reevaluating each participating provider
17 within a specified number of years after the provider's initial acceptance for
18 participation. The reevaluation shall include all of the following:

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

20 609.32 (2) (c) A ~~managed care~~ defined network plan may not require a
21 participating provider to provide services that are outside the scope of his or her
22 license or certificate.

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

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

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

6 609.34 (2) A preferred provider plan may contract for services related to clinical
7 protocols and utilization management. A preferred provider plan or its designee is
8 required to appoint a medical director only to the extent that the preferred provider
9 plan or its designee assumes direct responsibility for clinical protocols and
10 utilization management policies of the plan. The medical director, who shall be a
11 physician, shall be responsible for such protocols and policies of the plan.

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

13 **609.35 Applicability of requirements to preferred provider plans.**

14 Notwithstanding ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), a preferred
15 provider plan that does not cover the same services when performed by a
16 nonparticipating provider that it covers when those services are performed by a
17 participating provider is subject to the requirements under ss. 609.22 (2), (3), (4), and
18 (7), 609.32 (1), and 609.34 (1).

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

20 609.36 (1) (a) (intro.) A ~~managed-care~~ defined network plan shall provide to the
21 commissioner information related to all of the following:

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

23 609.36 (2) **CONFIDENTIALITY.** A ~~managed-care~~ defined network plan shall
24 establish written policies and procedures, consistent with ss. 51.30, 146.82, and

1 252.15, for the handling of medical records and enrollee communications to ensure
2 confidentiality.

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

4 **609.38 Oversight.** The office shall perform examinations of insurers that
5 issue ~~managed care~~ defined network plans consistent with ss. 601.43 and 601.44.
6 The commissioner shall by rule develop standards for ~~managed care~~ defined network
7 plans for compliance with the requirements under this chapter.

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

9 609.65 (1) (intro.) If an enrollee of a limited service health organization,
10 preferred provider plan, or ~~managed care~~ defined network plan is examined,
11 evaluated, or treated for a nervous or mental disorder pursuant to an emergency
12 detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m)
13 or (4r) or ch. 980, then, notwithstanding the limitations regarding participating
14 providers, primary providers, and referrals under ss. 609.01 (2) to (4) and 609.05 (3),
15 the limited service health organization, preferred provider plan, or ~~managed care~~
16 defined network plan shall do all of the following:

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

18 609.65 (1) (a) If the provider performing the examination, evaluation, or
19 treatment has a provider agreement with the limited service health organization,
20 preferred provider plan, or ~~managed care~~ defined network plan which covers the
21 provision of that service to the enrollee, make the service available to the enrollee in
22 accordance with the terms of the limited service health organization, preferred
23 provider plan, or ~~managed care~~ defined network plan and the provider agreement.

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

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

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

9 609.65 (1) (b) 1. The service is provided pursuant to a commitment or a court
10 order, except that reimbursement is not required under this subdivision if the limited
11 service health organization, preferred provider plan, or ~~managed care~~ defined
12 network plan could have provided the service through a provider with whom it has
13 a provider agreement.

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

15 609.65 (1) (b) 2. The service is provided pursuant to an emergency detention
16 under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20
17 and the provider notifies the limited service health organization, preferred provider
18 plan, or ~~managed care~~ defined network plan within 72 hours after the initial
19 provision of the service.

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

21 609.65 (2) If after receiving notice under sub. (1) (b) 2. the limited service health
22 organization, preferred provider plan, or ~~managed care~~ defined network plan
23 arranges for services to be provided by a provider with whom it has a provider
24 agreement, the limited service health organization, preferred provider plan, or

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

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

4 609.65 (3) A limited service health organization, preferred provider plan, or
5 ~~managed care~~ defined network plan is only required to make available, or make
6 reimbursement for, an examination, evaluation, or treatment under sub. (1) to the
7 extent that the limited service health organization, preferred provider plan, or
8 ~~managed care~~ defined network plan would have made the medically necessary
9 service available to the enrollee or reimbursed the provider for the service if any
10 referrals required under s. 609.05 (3) had been made and the service had been
11 performed by a participating provider.

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

13 609.655 (1) (a) 1. Is covered as a dependent child under the terms of a policy
14 or certificate issued by a ~~managed care~~ defined network plan insurer.

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

16 609.655 (1) (a) 2. Is enrolled in a school located in this state but outside the
17 geographical service area of the ~~managed care~~ defined network plan.

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

19 609.655 (2) If a policy or certificate issued by a ~~managed care~~ defined network
20 plan insurer provides coverage of outpatient services provided to a dependent
21 student, the policy or certificate shall provide coverage of outpatient services, to the
22 extent and in the manner required under sub. (3), that are provided to the dependent
23 student while he or she is attending a school located in this state but outside the
24 geographical service area of the ~~managed care~~ defined network plan,

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

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

4 609.655 (3) (intro.) Except as provided in sub. (5), a ~~managed care~~ defined
5 network plan shall provide coverage for all of the following services:

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

7 609.655 (3) (a) A clinical assessment of the dependent student's nervous or
8 mental disorders or alcoholism or other drug abuse problems, conducted by a
9 provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in
10 reasonably close proximity to the school in which the dependent student is enrolled
11 and who may be designated by the ~~managed care~~ defined network plan.

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

13 609.655 (3) (b) (intro.) If outpatient services are recommended in the clinical
14 assessment conducted under par. (a), the recommended outpatient services
15 consisting of not more than 5 visits to an outpatient treatment facility or other
16 provider that is located in this state and in reasonably close proximity to the school
17 in which the dependent student is enrolled and that may be designated by the
18 ~~managed care~~ defined network plan, except as follows:

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

20 609.655 (3) (b) 1. Coverage is not required under this paragraph if the medical
21 director of the ~~managed care~~ defined network plan determines that the nature of the
22 treatment recommended in the clinical assessment will prohibit the dependent
23 student from attending school on a regular basis.

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

1 609.655 (4) (a) Upon completion of the 5 visits for outpatient services covered
2 under sub. (3) (b), the medical director of the ~~managed care~~ defined network plan and
3 the clinician treating the dependent student shall review the dependent student's
4 condition and determine whether it is appropriate to continue treatment of the
5 dependent student's nervous or mental disorders or alcoholism or other drug abuse
6 problems in reasonably close proximity to the school in which the student is enrolled.
7 The review is not required if the dependent student is no longer enrolled in the school
8 or if the coverage limits under the policy or certificate for treatment of nervous or
9 mental disorders or alcoholism or other drug abuse problems have been exhausted.

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

11 609.655 (4) (b) Upon completion of the review under par. (a), the medical
12 director of the ~~managed care~~ defined network plan shall determine whether the
13 policy or certificate will provide coverage of any further treatment for the dependent
14 student's nervous or mental disorder or alcoholism or other drug abuse problems that
15 is provided by a provider located in reasonably close proximity to the school in which
16 the student is enrolled. If the dependent student disputes the medical director's
17 determination, the dependent student may submit a written grievance under the
18 ~~managed care~~ defined network plan's internal grievance procedure established
19 under s. 632.83.

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

21 609.655 (5) (a) A policy or certificate issued by a ~~managed care~~ defined network
22 plan insurer is required to provide coverage for the services specified in sub. (3) only
23 to the extent that the policy or certificate would have covered the service if it had been
24 provided to the dependent student by a participating provider within the
25 geographical service area of the ~~managed care~~ defined network plan.

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

2 609.655 (5) (b) Paragraph (a) does not permit a ~~managed care defined network~~
3 plan to reimburse a provider for less than the full cost of the services provided or an
4 amount negotiated with the provider, solely because the reimbursement rate for the
5 service would have been less if provided by a participating provider within the
6 geographical service area of the ~~managed care defined network~~ plan.

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

8 **609.70 Chiropractic coverage.** Limited service health organizations,
9 preferred provider plans, and ~~managed care defined network~~ plans are subject to s.
10 632.87 (3).

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

12 **609.75 Adopted children coverage.** Limited service health organizations,
13 preferred provider plans, and ~~managed care defined network~~ plans are subject to s.
14 632.896. Coverage of health care services obtained by adopted children and children
15 placed for adoption may be subject to any requirements that the limited service
16 health organization, preferred provider plan, or ~~managed care defined network~~ plan
17 imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained
18 by other enrollees.

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

20 **609.77 Coverage of breast reconstruction.** Limited service health
21 organizations, preferred provider plans, and ~~managed care defined network~~ plans
22 are subject to s. 632.895 (13).

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

24 **609.78 Coverage of treatment for the correction of**
25 **temporomandibular disorders.** Limited service health organizations, preferred

1 provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895
2 (11).

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

4 **609.79 Coverage of hospital and ambulatory surgery center charges**
5 **and anesthetics for dental care.** Limited service health organizations, preferred
6 provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895
7 (12).

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

9 **609.80 Coverage of mammograms.** ~~Managed care~~ Defined network plans
10 are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be
11 subject to any requirements that the ~~managed care~~ defined network plan imposes
12 under s. 609.05 (2) and (3) on the coverage of other health care services obtained by
13 enrollees.

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

15 **609.81 Coverage related to HIV infection.** Limited service health
16 organizations, preferred provider plans, and ~~managed care~~ defined network plans
17 are subject to s. 631.93. ~~Managed care~~ Defined network plans are subject to s.
18 632.895 (9).

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

20 **609.82 Coverage without prior authorization for emergency medical**
21 **condition treatment.** Limited service health organizations, preferred provider
22 plans, and ~~managed care~~ defined network plans are subject to s. 632.85.

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

1 **609.83 Coverage of drugs and devices.** Limited service health
2 organizations, preferred provider plans, and ~~managed care~~ defined network plans
3 are subject to s. 632.853.

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

5 **609.84 Experimental treatment.** Limited service health organizations,
6 preferred provider plans, and ~~managed care~~ defined network plans are subject to s.
7 632.855.

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

9 **609.88 Coverage of immunizations.** ~~Managed care~~ Defined network plans
10 are subject to s. 632.895 (14).

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

12 **609.89 Written reason for coverage denial.** Limited service health
13 organizations, preferred provider plans, and ~~managed care~~ defined network plans
14 are subject to s. 631.17.

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

16 **609.90 Restrictions related to domestic abuse.** Limited service health
17 organizations, preferred provider plans, and ~~managed care~~ defined network plans
18 are subject to s. 631.95.”

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

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

21 632.895 (14) (c) The coverage required under par. (b) may not be subject to any
22 deductibles, copayments, or coinsurance under the policy or plan. This paragraph
23 applies to a ~~managed care~~ defined network plan, as defined in s. 609.01 (3e) (1b), only

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

3 **SECTION 3763g.** 632.895 (14) (d) 3. of the statutes is amended to read:

4 632.895 (14) (d) 3. A health care plan offered by a limited service health
5 organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined
6 in s. 609.01 (4), that is not a ~~managed-care~~ defined network plan, as defined in s.
7 609.01 ~~(3e)~~ (1b).”

8 (END)

A large, handwritten signature or set of initials in black ink, located in the lower right quadrant of the page. The signature appears to consist of a large 'D' followed by a horizontal line and some cursive letters, possibly 'W. G.'.

Insert 4-3

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

3741cmr

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 Opins 4-3)

D-note

¶

This redraft makes some

language changes in s. 609.20(1m)(intro.)

(as renumbered) ~~regarding~~ 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.

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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

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

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

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

4 40.51 (12) Every ~~managed-care~~ defined network plan, as defined in s. 609.01

5 (3e) (1b), and every limited service health organization, as defined in s. 609.01 (3),

6 that is offered by the state under sub. (6) shall comply with ch. 609.

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

8 40.51 (13) Every ~~managed-care~~ defined network plan, as defined in s. 609.01

9 (3c) (1b), and every limited service health organization, as defined in s. 609.01 (3),

1 that is offered by the group insurance board under sub. (7) shall comply with ch.
2 609.”.

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

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

5 **CHAPTER 609**

6 **MANAGED CARE DEFINED NETWORK PLANS**

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

8 609.01 (1d) “Enrollee” means, with respect to a ~~managed care~~ defined network
9 plan, preferred provider plan, or limited service health organization, a person who
10 is entitled to receive health care services under the plan.

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

13 609.01 (1b) “~~Managed care~~ Defined network plan” means a health benefit plan
14 that requires an enrollee of the health benefit plan, or creates incentives, including
15 financial incentives, for an enrollee of the health benefit plan, to use providers that
16 are managed, owned, under contract with, or employed by the insurer offering the
17 health benefit plan.

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

19 609.01 (3m) “Participating” means, with respect to a physician or other
20 provider, under contract with a ~~managed care~~ defined network plan, preferred
21 provider plan, or limited service health organization to provide health care services,
22 items or supplies to enrollees of the ~~managed care~~ defined network plan, preferred
23 provider plan, or limited service health organization.

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

1 609.01 (4) “Preferred provider plan” means a health care plan offered by an
2 organization established under ch. 185, 611, 613, or 614 or issued a certificate of
3 authority under ch. 618 that makes available to its enrollees, without referral and
4 for consideration other than predetermined periodic fixed payments, coverage of
5 either comprehensive health care services or a limited range of health care services,
6 regardless of whether the health care services are performed by participating or
7 nonparticipating providers participating in the plan.

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

9 609.01 (5) “Primary provider” means a participating primary care physician,
10 or other participating provider authorized by the ~~managed care~~ defined network
11 plan, preferred provider plan, or limited service health organization to serve as a
12 primary provider, who coordinates and may provide ongoing care to an enrollee.

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

14 609.05 (1) Except as provided in subs. (2) and (3), a limited service health
15 organization, preferred provider plan, or ~~managed care~~ defined network plan shall
16 permit its enrollees to choose freely among participating providers.

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

18 609.05 (2) Subject to s. 609.22 (4) and (4m), a limited service health
19 organization, preferred provider plan, or ~~managed care~~ defined network plan may
20 require an enrollee to designate a primary provider and to obtain health care services
21 from the primary provider when reasonably possible.

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

23 609.05 (3) Except as provided in ss. 609.22 (4m), 609.65, and 609.655, a limited
24 service health organization, preferred provider plan, or ~~managed care~~ defined
25 network plan may require an enrollee to obtain a referral from the primary provider

1 designated under sub. (2) to another participating provider prior to obtaining health
2 care services from that participating provider.

3 **SECTION 3741cmr.** 609.10 (5) of the statutes is amended to read:

4 609.10 (5) The commissioner may establish by rule standards in addition to
5 these any established under s. 609.20 for what constitutes adequate notice and
6 complete and understandable information under sub. (1) (c).

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

8 **609.17 Reports of disciplinary action.** Every limited service health
9 organization, preferred provider plan, and ~~managed care~~ defined network plan shall
10 notify the medical examining board or appropriate affiliated credentialing board
11 attached to the medical examining board of any disciplinary action taken against a
12 participating provider who holds a license or certificate granted by the board or
13 affiliated credentialing board.

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

15 **609.20 (title) Rules for preferred provider and ~~managed care~~ defined**
16 **network plans.**

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

19 609.20 (1m) (intro.) The commissioner ~~shall~~ may promulgate rules relating to
20 preferred provider plans and ~~managed care~~ defined network plans for all any of the
21 following purposes, as appropriate:

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

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

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

1 609.20 (2m) Any rule promulgated under this chapter shall recognize the
2 differences between preferred provider plans and other types of defined network
3 plans, take into account the fact that preferred provider plans provide coverage for
4 the services of nonparticipating providers, and be appropriate to the type of plan to
5 which the rule applies.

6 **SECTION 3741emt.** 609.20 (3) of the statutes, as affected by 1999 Wisconsin Act
7 9, is renumbered 609.20 (1m) (c).

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

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

11 609.22 (1) PROVIDERS. A ~~managed-care~~ defined network plan shall include a
12 sufficient number, and sufficient types, of qualified providers to meet the anticipated
13 needs of its enrollees, with respect to covered benefits, as appropriate to the type of
14 plan and consistent with normal practices and standards in the geographic area.

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

16 609.22 (2) ADEQUATE CHOICE. A ~~managed-care~~ defined network plan that is not
17 a preferred provider plan shall ensure that, with respect to covered benefits, each
18 enrollee has adequate choice among participating providers and that the providers
19 are accessible and qualified.

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

21 609.22 (3) PRIMARY PROVIDER SELECTION. A ~~managed-care~~ defined network plan
22 that is not a preferred provider plan shall permit each enrollee to select his or her
23 own primary provider from a list of participating primary care physicians and any
24 other participating providers that are authorized by the ~~managed-care~~ defined
25 network plan to serve as primary providers. The list shall be updated on an ongoing

1 basis and shall include a sufficient number of primary care physicians and any other
2 participating providers authorized by the plan to serve as primary providers who are
3 accepting new enrollees.

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

5 609.22 (4) (a) 1. If a ~~managed-care~~ defined network plan that is not a preferred
6 provider plan requires a referral to a specialist for coverage of specialist services, the
7 ~~managed-care~~ defined network plan that is not a preferred provider plan shall
8 establish a procedure by which an enrollee may apply for a standing referral to a
9 specialist. The procedure must specify the criteria and conditions that must be met
10 in order for an enrollee to obtain a standing referral.

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

12 609.22 (4) (a) 2. A ~~managed-care~~ defined network plan that is not a preferred
13 provider plan may require the enrollee's primary provider to remain responsible for
14 coordinating the care of an enrollee who receives a standing referral to a specialist.
15 A ~~managed-care~~ defined network plan that is not a preferred provider plan may
16 restrict the specialist from making any secondary referrals without prior approval
17 by the enrollee's primary provider. If an enrollee requests primary care services from
18 a specialist to whom the enrollee has a standing referral, the specialist, in agreement
19 with the enrollee and the enrollee's primary provider, may provide primary care
20 services to the enrollee in accordance with procedures established by the ~~managed~~
21 ~~care~~ defined network plan that is not a preferred provider plan.

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

23 609.22 (4) (a) 3. A ~~managed-care~~ defined network plan that is not a preferred
24 provider plan must include information regarding referral procedures in policies or

1 certificates provided to enrollees and must provide such information to an enrollee
2 or prospective enrollee upon request.

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

4 609.22 (4m) (a) A ~~managed-care~~ defined network plan that provides coverage
5 of obstetric or gynecologic services may not require a female enrollee of the ~~managed~~
6 ~~care~~ defined network plan to obtain a referral for covered obstetric or gynecologic
7 benefits provided by a participating provider who is a physician licensed under ch.
8 448 and who specializes in obstetrics and gynecology, regardless of whether the
9 participating provider is the enrollee's primary provider. Notwithstanding sub. (4),
10 the ~~managed-care~~ defined network plan may not require the enrollee to obtain a
11 standing referral under the procedure established under sub. (4) (a) for covered
12 obstetric or gynecologic benefits.

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

14 609.22 (4m) (b) (intro.) A ~~managed-care~~ defined network plan under par. (a)
15 may not do any of the following:

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

17 609.22 (4m) (c) A ~~managed-care~~ defined network plan under par. (a) shall
18 provide written notice of the requirement under par. (a) in every policy or group
19 certificate issued by the ~~managed-care~~ defined network plan.

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

21 609.22 (5) SECOND OPINIONS. A ~~managed-care~~ defined network plan shall
22 provide an enrollee with coverage for a 2nd opinion from another participating
23 provider.

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

1 609.22 (6) EMERGENCY CARE. (intro.) Notwithstanding s. 632.85, if a ~~managed~~
2 ~~care~~ defined network plan provides coverage of emergency services, with respect to
3 covered benefits, the ~~managed-care~~ defined network plan shall do all of the following:

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

5 609.22 (7) TELEPHONE ACCESS. A ~~managed-care~~ defined network plan that is not
6 a preferred provider plan shall provide telephone access for sufficient time during
7 business and evening hours to ensure that enrollees have adequate access to routine
8 health care services for which coverage is provided under the plan. A ~~managed-care~~
9 defined network plan that is not a preferred provider plan shall provide 24-hour
10 telephone access to the plan or to a participating provider for emergency care, or
11 authorization for care, for which coverage is provided under the plan.

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

13 609.22 (8) ACCESS PLAN FOR CERTAIN ENROLLEES. A ~~managed-care~~ defined
14 network plan shall develop an access plan to meet the needs, with respect to covered
15 benefits, of its enrollees who are members of underserved populations. If a
16 significant number of enrollees of the plan customarily use languages other than
17 English, the ~~managed-care~~ defined network plan shall provide access to translation
18 services fluent in those languages to the greatest extent possible.

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

20 609.24 (1) (a) (intro.) Subject to pars. (b) and (c) and except as provided in par.
21 (d), a ~~managed-care~~ defined network plan shall, with respect to covered benefits,
22 provide coverage to an enrollee for the services of a provider, regardless of whether
23 the provider is a participating provider at the time the services are provided, if the
24 ~~managed-care~~ defined network plan represented that the provider was, or would be,

1 a participating provider in marketing materials that were provided or available to
2 the enrollee at any of the following times:

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

4 609.24 (1) (b) (intro.) Except as provided in par. (d), a ~~managed-care~~ defined
5 network plan shall provide the coverage required under par. (a) with respect to the
6 services of a provider who is a primary care physician for the following period of time:

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

8 609.24 (1) (c) (intro.) Except as provided in par. (d), if an enrollee is undergoing
9 a course of treatment with a participating provider who is not a primary care
10 physician and whose participation with the plan terminates, the ~~managed-care~~
11 defined network plan shall provide the coverage under par. (a) with respect to the
12 services of the provider for the following period of time:

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

14 609.24 (1) (d) 1. The provider no longer practices in the ~~managed-care~~ defined
15 network plan's geographic service area.

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

17 609.24 (1) (d) 2. The insurer issuing the ~~managed-care~~ defined network plan
18 terminates or terminated the provider's contract for misconduct on the part of the
19 provider.

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

21 609.24 (1) (e) 1. An insurer issuing a ~~managed-care~~ defined network plan shall
22 include in its provider contracts provisions addressing reimbursement to providers
23 for services rendered under this section.

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

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

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

6 609.24 (4) NOTICE OF PROVISIONS. A defined network plan shall notify all plan
7 enrollees of the provisions under this section whenever a participating provider's
8 participation with the plan terminates, or shall, by contract, require a participating
9 provider to notify all plan enrollees of the provisions under this section if the
10 participating provider's participation with the plan terminates.

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

12 609.30 (1) PLAN MAY NOT CONTRACT. A ~~managed care~~ defined network plan may
13 not contract with a participating provider to limit the provider's disclosure of
14 information, to or on behalf of an enrollee, about the enrollee's medical condition or
15 treatment options.

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

17 609.30 (2) PLAN MAY NOT PENALIZE OR TERMINATE. A participating provider may
18 discuss, with or on behalf of an enrollee, all treatment options and any other
19 information that the provider determines to be in the best interest of the enrollee.
20 A ~~managed care~~ defined network plan may not penalize or terminate the contract of
21 a participating provider because the provider makes referrals to other participating
22 providers or discusses medically necessary or appropriate care with or on behalf of
23 an enrollee.

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

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

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

7 609.32 (1m) PROCEDURE FOR REMEDIAL ACTION; PREFERRED PROVIDER PLANS. A
8 preferred provider plan shall develop a procedure for remedial action to address
9 quality problems, including written procedures for taking appropriate corrective
10 action.

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

12 609.32 (2) (a) A ~~managed care defined network~~ plan shall develop a process for
13 selecting participating providers, including written policies and procedures that the
14 plan uses for review and approval of providers. After consulting with appropriately
15 qualified providers, the plan shall establish minimum professional requirements for
16 its participating providers. The process for selection shall include verification of a
17 provider's license or certificate, including the history of any suspensions or
18 revocations, and the history of any liability claims made against the provider.

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

20 609.32 (2) (b) (intro.) A ~~managed care defined network~~ plan shall establish in
21 writing a formal, ongoing process for reevaluating each participating provider
22 within a specified number of years after the provider's initial acceptance for
23 participation. The reevaluation shall include all of the following:

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

1 609.32 (2) (c) A ~~managed-care~~ defined network plan may not require a
2 participating provider to provide services that are outside the scope of his or her
3 license or certificate.

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

6 609.34 (1) A ~~managed-care~~ defined network plan that is not a preferred
7 provider plan shall appoint a physician as medical director. The medical director
8 shall be responsible for clinical protocols, quality assurance activities, and
9 utilization management policies of the plan.

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

11 609.34 (2) A preferred provider plan may contract for services related to clinical
12 protocols and utilization management. A preferred provider plan or its designee is
13 required to appoint a medical director only to the extent that the preferred provider
14 plan or its designee assumes direct responsibility for clinical protocols and
15 utilization management policies of the plan. The medical director, who shall be a
16 physician, shall be responsible for such protocols and policies of the plan.

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

18 **609.35 Applicability of requirements to preferred provider plans.**

19 Notwithstanding ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), a preferred
20 provider plan that does not cover the same services when performed by a
21 nonparticipating provider that it covers when those services are performed by a
22 participating provider is subject to the requirements under ss. 609.22 (2), (3), (4), and
23 (7), 609.32 (1), and 609.34 (1).

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

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

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

4 609.36 (2) CONFIDENTIALITY. A ~~managed-care~~ defined network plan shall
5 establish written policies and procedures, consistent with ss. 51.30, 146.82, and
6 252.15, for the handling of medical records and enrollee communications to ensure
7 confidentiality.

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

9 **609.38 Oversight.** The office shall perform examinations of insurers that
10 issue ~~managed-care~~ defined network plans consistent with ss. 601.43 and 601.44.
11 The commissioner shall by rule develop standards for ~~managed-care~~ defined network
12 plans for compliance with the requirements under this chapter.

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

14 609.65 (1) (intro.) If an enrollee of a limited service health organization,
15 preferred provider plan, or ~~managed-care~~ defined network plan is examined,
16 evaluated, or treated for a nervous or mental disorder pursuant to an emergency
17 detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m)
18 or (4r) or ch. 980, then, notwithstanding the limitations regarding participating
19 providers, primary providers, and referrals under ss. 609.01 (2) to (4) and 609.05 (3),
20 the limited service health organization, preferred provider plan, or ~~managed-care~~
21 defined network plan shall do all of the following:

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

23 609.65 (1) (a) If the provider performing the examination, evaluation, or
24 treatment has a provider agreement with the limited service health organization,
25 preferred provider plan, or ~~managed-care~~ defined network plan which covers the

1 provision of that service to the enrollee, make the service available to the enrollee in
2 accordance with the terms of the limited service health organization, preferred
3 provider plan, or ~~managed-care~~ defined network plan and the provider agreement.

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

5 609.65 (1) (b) (intro.) If the provider performing the examination, evaluation
6 or treatment does not have a provider agreement with the limited service health
7 organization, preferred provider plan, or ~~managed-care~~ defined network plan which
8 covers the provision of that service to the enrollee, reimburse the provider for the
9 examination, evaluation, or treatment of the enrollee in an amount not to exceed the
10 maximum reimbursement for the service under the medical assistance program
11 under subch. IV of ch. 49, if any of the following applies:

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

13 609.65 (1) (b) 1. The service is provided pursuant to a commitment or a court
14 order, except that reimbursement is not required under this subdivision if the limited
15 service health organization, preferred provider plan, or ~~managed-care~~ defined
16 network plan could have provided the service through a provider with whom it has
17 a provider agreement.

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

19 609.65 (1) (b) 2. The service is provided pursuant to an emergency detention
20 under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20
21 and the provider notifies the limited service health organization, preferred provider
22 plan, or ~~managed-care~~ defined network plan within 72 hours after the initial
23 provision of the service.

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

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

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

8 609.65 (3) A limited service health organization, preferred provider plan, or
9 ~~managed-care~~ defined network plan is only required to make available, or make
10 reimbursement for, an examination, evaluation, or treatment under sub. (1) to the
11 extent that the limited service health organization, preferred provider plan, or
12 ~~managed-care~~ defined network plan would have made the medically necessary
13 service available to the enrollee or reimbursed the provider for the service if any
14 referrals required under s. 609.05 (3) had been made and the service had been
15 performed by a participating provider.

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

17 609.655 (1) (a) 1. Is covered as a dependent child under the terms of a policy
18 or certificate issued by a ~~managed-care~~ defined network plan insurer.

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

20 609.655 (1) (a) 2. Is enrolled in a school located in this state but outside the
21 geographical service area of the ~~managed-care~~ defined network plan.

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

23 609.655 (2) If a policy or certificate issued by a ~~managed-care~~ defined network
24 plan insurer provides coverage of outpatient services provided to a dependent
25 student, the policy or certificate shall provide coverage of outpatient services, to the

1 extent and in the manner required under sub. (3), that are provided to the dependent
2 student while he or she is attending a school located in this state but outside the
3 geographical service area of the ~~managed-care~~ defined network plan,
4 notwithstanding the limitations regarding participating providers, primary
5 providers, and referrals under ss. 609.01 (2) and 609.05 (3).

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

7 609.655 (3) (intro.) Except as provided in sub. (5), a ~~managed-care~~ defined
8 network plan shall provide coverage for all of the following services:

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

10 609.655 (3) (a) A clinical assessment of the dependent student's nervous or
11 mental disorders or alcoholism or other drug abuse problems, conducted by a
12 provider described in s. 632.89 (1) (e) 2. or 3. who is located in this state and in
13 reasonably close proximity to the school in which the dependent student is enrolled
14 and who may be designated by the ~~managed-care~~ defined network plan.

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

16 609.655 (3) (b) (intro.) If outpatient services are recommended in the clinical
17 assessment conducted under par. (a), the recommended outpatient services
18 consisting of not more than 5 visits to an outpatient treatment facility or other
19 provider that is located in this state and in reasonably close proximity to the school
20 in which the dependent student is enrolled and that may be designated by the
21 ~~managed-care~~ defined network plan, except as follows:

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

23 609.655 (3) (b) 1. Coverage is not required under this paragraph if the medical
24 director of the ~~managed-care~~ defined network plan determines that the nature of the

1 treatment recommended in the clinical assessment will prohibit the dependent
2 student from attending school on a regular basis.

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

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

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

14 609.655 (4) (b) Upon completion of the review under par. (a), the medical
15 director of the ~~managed-care~~ defined network plan shall determine whether the
16 policy or certificate will provide coverage of any further treatment for the dependent
17 student's nervous or mental disorder or alcoholism or other drug abuse problems that
18 is provided by a provider located in reasonably close proximity to the school in which
19 the student is enrolled. If the dependent student disputes the medical director's
20 determination, the dependent student may submit a written grievance under the
21 ~~managed-care~~ defined network plan's internal grievance procedure established
22 under s. 632.83.

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

24 609.655 (5) (a) A policy or certificate issued by a ~~managed-care~~ defined network
25 plan insurer is required to provide coverage for the services specified in sub. (3) only

1 to the extent that the policy or certificate would have covered the service if it had been
2 provided to the dependent student by a participating provider within the
3 geographical service area of the ~~managed care~~ defined network plan.

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

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

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

11 **609.70 Chiropractic coverage.** Limited service health organizations,
12 preferred provider plans, and ~~managed care~~ defined network plans are subject to s.
13 632.87 (3).

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

15 **609.75 Adopted children coverage.** Limited service health organizations,
16 preferred provider plans, and ~~managed care~~ defined network plans are subject to s.
17 632.896. Coverage of health care services obtained by adopted children and children
18 placed for adoption may be subject to any requirements that the limited service
19 health organization, preferred provider plan, or managed care defined network plan
20 imposes under s. 609.05 (2) and (3) on the coverage of health care services obtained
21 by other enrollees.

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

23 **609.77 Coverage of breast reconstruction.** Limited service health
24 organizations, preferred provider plans, and ~~managed care~~ defined network plans
25 are subject to s. 632.895 (13).

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

2 **609.78 Coverage of treatment for the correction of**
3 **temporomandibular disorders.** Limited service health organizations, preferred
4 provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895
5 (11).

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

7 **609.79 Coverage of hospital and ambulatory surgery center charges**
8 **and anesthetics for dental care.** Limited service health organizations, preferred
9 provider plans, and ~~managed care~~ defined network plans are subject to s. 632.895
10 (12).

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

12 **609.80 Coverage of mammograms.** ~~Managed care~~ Defined network plans
13 are subject to s. 632.895 (8). Coverage of mammograms under s. 632.895 (8) may be
14 subject to any requirements that the ~~managed care~~ defined network plan imposes
15 under s. 609.05 (2) and (3) on the coverage of other health care services obtained by
16 enrollees.

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

18 **609.81 Coverage related to HIV infection.** Limited service health
19 organizations, preferred provider plans, and ~~managed care~~ defined network plans
20 are subject to s. 631.93. ~~Managed care~~ Defined network plans are subject to s.
21 632.895 (9).

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

23 **609.82 Coverage without prior authorization for emergency medical**
24 **condition treatment.** Limited service health organizations, preferred provider
25 plans, and ~~managed care~~ defined network plans are subject to s. 632.85.

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

2 **609.83 Coverage of drugs and devices.** Limited service health
3 organizations, preferred provider plans, and ~~managed care~~ defined network plans
4 are subject to s. 632.853.

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

6 **609.84 Experimental treatment.** Limited service health organizations,
7 preferred provider plans, and ~~managed care~~ defined network plans are subject to s.
8 632.855.

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

10 **609.88 Coverage of immunizations.** ~~Managed care~~ Defined network plans
11 are subject to s. 632.895 (14).

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

13 **609.89 Written reason for coverage denial.** Limited service health
14 organizations, preferred provider plans, and ~~managed care~~ defined network plans
15 are subject to s. 631.17.

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

17 **609.90 Restrictions related to domestic abuse.** Limited service health
18 organizations, preferred provider plans, and ~~managed care~~ defined network plans
19 are subject to s. 631.95.”.

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

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

22 632.895 (14) (c) The coverage required under par. (b) may not be subject to any
23 deductibles, copayments, or coinsurance under the policy or plan. This paragraph
24 applies to a ~~managed care~~ defined network plan, as defined in s. 609.01 ~~(3e)~~ (1b), only

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

3 **SECTION 3763g.** 632.895 (14) (d) 3. of the statutes is amended to read:

4 632.895 (14) (d) 3. A health care plan offered by a limited service health
5 organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined
6 in s. 609.01 (4), that is not a ~~managed care~~ defined network plan, as defined in s.
7 609.01 (~~3e~~) (1b).”

8

(END)