2005 DRAFTING REQUEST

Bill

Received: **12/20/2005**

Received By: **chanaman**

Wanted: **As time permits**

Identical to LRB:

For: **Ann Nischke (608) 266-8580**

By/Representing:

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

Drafter: **chanaman**

May Contact:

Addl. Drafters: **pkahler**

Subject: **Insurance - health**

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Nischke@legis.state.wi.us**

Carbon copy (CC:) to: **joyce.kiel@legis.state.wi.us**
richard.sweet@legis.state.wi.us

Pre Topic:

No specific pre topic given

Topic:

Defined network plans

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/P1	chanaman 01/19/2006	jdyer 01/20/2006	jfrantze 01/20/2006	_____ _____	lnorthro 01/20/2006		
/P2	pkahler 02/03/2006 chanaman 02/10/2006	jdyer 02/10/2006	rschluet 02/10/2006	_____ _____ _____ _____	sbasford 02/10/2006		
/1	pkahler	kfollett	jfrantze	_____	lnorthro	lnorthro	

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	02/14/2006 chanaman 02/15/2006	02/15/2006	02/15/2006	_____ _____ _____	02/15/2006	02/20/2006	

FE Sent For:

<END>

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Addl. Drafters:

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Extra Copies: **PJK**

Submit via email: **YES**

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/P2	pkahler 02/03/2006 chanaman 02/10/2006	jdyer 02/10/2006 1 1/cjf 2/15	rschluet 02/10/2006	_____ _____ _____ _____	sbasford 02/10/2006		

2/15 2/15 2/15

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Addl. Drafters:

Subject: **Insurance - health**

Extra Copies: **PJK**

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Drafting History:

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/P1	chanaman 01/19/2006	lrb_editor 1/20 jcd 1/20					

FE Sent For:

<END>

WAPN

Wisconsin Association of Provider Networks
Suggested Changes and Compromises to CR05-059
October 25, 2005

Delete the inclusion of limited scope plans
Delete 9.01 (10m)

Compromise on preferred provider plan same service requirements
Agree to a coinsurance floor of 50%; and either:

Delete the disclosure language within the regulation and have the OCI develop a consumers guide to out of network coverages for defined network plans,

Or,

Leave the disclosure language in the regulation but have it apply equally to all defined network plans.

Compromise on pre-authorization provision
Change the language to allow the OCI to review this issue through the complaint process and report back to the legislature in one year as to any documented problems with insurers using pre-authorization for denying access.

Compromise on additional "substantial coverage" provisions
Agree to a coinsurance differential of 40%, but delete the deductible and co-pay requirements and either:

Delete the disclosure language within the regulation and have the OCI develop a consumers guide to out of network coverages for defined network plans,

Or,

Leave the disclosure language in the regulation but have it apply equally to all defined network plans.

Delete the inclusion of PPP's in Access Standards
Delete 9.32 (2)(a) & (2)(b)

Delete the inclusion of PPP's in new provisions of Access Standards
Delete 9.32 (2)(c), (2)(e) & (2)(f)

Compromise on Provider Directories and Appendix D
Change 9.32 (2)(d) to allow for substantially similar language

Agree to Emergency Services Provision
Agree to 9.32 (2)(g), but ask the OCI to reconsider adding the stabilization language.

609.35

(1) define

cov the same services means: nonp

does not cover same services if:

(1) service not covered

(2) services covered but copays coinsurance difference between what enrollee pays for the 2 is more than 40%

(40% differential)

(3) PPP pay for at least 50% do not p insured pay > 50%

(PPP must pay for at least 50%)

see 9.25(1) (a) + (b)

(2) ~~[illegible]~~ & have OCI develop consumer guide

(3) re ~~to~~ ltd scope plan

OCI may ltds ~~as~~ not promul rules that sub 1 s p to

609.~~22~~

609.24

609.30

609.32

609.34

~~[illegible]~~

9.42

4 prohibit OCI from rules requiring regarding requiring that contract to port provides specific categories of operation

5 geo location

Appen D

if OCI requires criteria that, may not require the exact language (allow most similar) (which is type E)

6 study or preempt & prohibit OCI from doing rule

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB–4275/P1
PJK&CMH:...:...

MONDAY

+PJK

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

LPS - Please check auto refs

Gen

AN ACT ...; **relating to:** defined network plans.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a later version.

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

SECTION 1. 601.47 (2m) of the statutes is created to read:

601.47 **(2m)** The commissioner shall prepare and publish a guide to out–of–network coverage for defined network plans and distribute it in a manner that the commissioner determines. The cost of publication and distribution may be paid from the appropriation under s. 20.145 (1) (g).

SECTION 2. 601.47 (3) of the statutes is amended to read:

601.47 **(3)** FREE DISTRIBUTION. The commissioner may furnish free copies of the publications prepared under subs. (1) ~~and~~, (2), and (2m) to public officers and

libraries in this state and elsewhere. The cost of free distribution shall be charged to the appropriation under s. 20.145 (1) (g).

History: 1971 c. 125; 1979 c. 102 ss. 75, 236 (6); 2001 a. 16.

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

609.20 **(3)** The commissioner may not promulgate a rule relating to a preferred provider plan for any of the following purposes:

(a) To require availability in specified geographical areas.

(b) To specify hours of operation, waiting times for appointments in participating provider offices, or care provided after business hours.

(c) To require a certain number of participating providers per enrollees.

(d) To require any contract that schedules nonemergency care to specify the name of any person participating in the care and to specify whether each person participating in the care is a participating provider or not.

****NOTE: Pam, I am almost afraid to put a note in here in case it reappears after going to a /1. I do not know how to change 9.32 (2) (d) to allow for substantially similar language since 9.32 (2) (d) does not exist in the statutes??

SECTION 4. 609.21 of the statutes is created to read:

609.21 Rules for limited scope plans. The commissioner may not promulgate a rule that subjects a limited scope plan to ss. 609.22, 609.24, 609.30, 609.32, 609.34, or 609.36.

INSERT 2-16

SECTION 5. 609.35 of the statutes is renumbered 609.35 (2).

SECTION 6. 609.35 (1) of the statutes is created to read:

609.35 **(1)** In this section, a preferred provider plan does not cover a service if any of the following apply:

(a) The preferred provider plan does not cover the service.

(b) The difference in coverage for the service between a participating provider and a nonparticipating provider is greater than 40 percent of the total cost of the service.

(c) The enrollee must pay for the service more than 50 percent of the costs of the service.

(END)

Insert 3-5

2005–2006 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–4275/P1ins
PJK:...:...

INSERT 2–10

between the preferred provider plan and a participating provider to require the participating provider, when scheduling

(END OF INSERT 2–10)

INSERT 2–12

(e) To require the services of nonparticipating providers to be covered at the same rate as the services of participating providers if the preferred provider plan fails to comply with certain requirements.

(END OF INSERT 2–12)

INSERT 2–14

(1) In this section, "limited scope plan" means a health care plan that provides limited–scope dental or vision benefits under a separate policy, certificate, or contract of insurance.

(2)

(END OF INSERT 2–14)

INSERT 2–16

SECTION 1. 609.20 (4) of the statutes is created to read:

609.20 **(4)** The commissioner may promulgate a rule that requires a preferred provider plan to include in its provider directory, in substantially similar language and in at least 11–point bold type, the following notice:

INSERT A
(TO INS 2-12)

INSERT 2-16

SECTION 2. 609.22 (4) (a) 2. of the statutes is renumbered 609.22 (4) (b).

INS. 2-16 cont

SECTION 3. 609.22 (4) (a) 2m. of the statutes is created to read:

609.22 **(4)** (a) 2m. The commissioner may not promulgate a rule relating to the use of prior authorization requirements by insurers offering defined network plans that are not preferred provider plans to deny access, or standing referrals, to specialists.

SECTION 4. 609.22 (4) (a) 3. of the statutes is renumbered 609.22 (4) (c).

(END OF INSERT 2–16)

INSERT 2–19

the same services when performed by a nonparticipating provider

(END OF INSERT 2–19)

INSERT 2–21

a service when performed by a nonparticipating provider that it covers when performed by a participating provider

(END OF INSERT 2–21)

INSERT 3–5

(b) The preferred provider plan covers a service when performed by a nonparticipating provider that it covers when performed by a participating provider, but either of the following applies:

1. The coinsurance differential between a participating and a nonparticipating provider for the service is more than 40 percent ~~or more~~.

2. Coinsurance for the service when performed by a nonparticipating provider is more than 50 percent ~~or more~~.

SECTION 5. 609.82 of the statutes is renumbered 609.82 (1).

SECTION 6. 609.82 (2) of the statutes is created to read:

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

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

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

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

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

SECTION 7. Nonstatutory provisions.

(1) STUDY ON USE OF PRIOR AUTHORIZATION TO DENY ACCESS. The office of the commissioner of insurance shall, through use of its complaint process, conduct a study on whether insurers that offer defined network plans, as defined in section 609.01 (1b) of the statutes, that are not preferred provider plans, as defined in section 609.01 (4) of the statutes, require prior authorization as part of the procedure for

obtaining a standing referral to a specialist under section 609.22 (4) of the statutes and shall determine if requiring prior authorization is used for denying standing referrals to specialists without just cause and with such frequency as to indicate a general business practice. Within one year after the effective date of this subsection, the office of the commissioner of insurance shall submit to the appropriate standing committees of the legislature, in the manner provided under section 13.172 (3) of the statutes, a report of the results of the study that includes documentation in support of any determinations made.

SECTION 8. Initial applicability.

(1) COVERAGE OF SAME SERVICES AND EMERGENCY MEDICAL SERVICES. The renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes first apply to all of the following:

(a) Except as provided in paragraph (b), policies, plans, or contracts that are issued or renewed on the effective date of this paragraph.

(b) Policies, plans, or contracts covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with the renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(END OF INSERT 3–5)

609.32, 609.34, ~~and 609.36,~~ and 632.83, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07 within 15 days of receipt of notice.

(5) (a) Any audits, and associated work papers of audits, conducted during the period of review relating to the business and service operation of the ~~managed care plan, preferred provider plan or limited service health organization~~ insurer offering a defined network or limited scope plan.

(6) (a) An access plan developed in accordance with s. Ins ~~9.34~~9.32 (1) and s. 609.22, Stats., requirements.

SECTION 23. INS 9.42 (9) is created to read:

9.42 (9) An insurer offering a preferred provider plan that is not also a defined network plan shall comply with this section to the extent applicable.

SECTION 24. Appendix D to ch. Ins 9 is created to read:

APPENDIX D. PREFERRED PROVIDER PLAN NOTICE TO ENROLLEES.

IMPORTANT NOTICE

You are strongly encouraged to contact us to verify the status of the providers involved in your care including, for example, the anesthesiologist, radiologist, pathologist, facility, clinic or laboratory, when scheduling appointments or elective procedures to determine whether each provider is a participating or nonparticipating provider. Such information may assist in your selection of provider(s) and will likely affect the level of copayment, deductible and amount of coinsurance applicable to the care you receive. The information contained in this directory may change during your plan year. Please contact [insert 800 and direct dial phone number of insurer] to learn more about the participating providers in your network and the implications, including financial, if you decide to receive your care from nonparticipating providers.

Suggested Changes
to
LRB-4275/P1

SECTION 1. 601.47 (2m) of the statutes is created to read:
601.47 **(2m)** The commissioner shall prepare and publish a guide ~~to~~ that generally describes out-of-network coverage for all defined network plans and distribute it in a manner that the commissioner determines. The cost of publication and distribution may be paid from the appropriation under s. 20.145 (1) (g).

SECTION 2. 601.47 (3) of the statutes is amended to read:
601.47 **(3)** FREE DISTRIBUTION. The commissioner may furnish free copies of the publications prepared under subs. (1) and, (2), and (2m) to public officers and libraries in this state and elsewhere. The cost of free distribution shall be charged to the appropriation under s. 20.145 (1) (g).

SECTION ?. 609.01 (4) of the statutes is amended to read:
609.01 **(4)** "Preferred provider plan" means a health ~~care~~ benefit plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, without referral and for consideration other than predetermined periodic fixed payments, coverage of either comprehensive health care services or a limited range of health care services, regardless of whether the health care services are performed by participating or nonparticipating providers.

SECTION 3. 609.20 (3) of the statutes is created to read:
609.20 **(3)** The commissioner may not promulgate a rule relating to a preferred provider plan for any of the following purposes:
~~(a) To require a specified availability within geographical areas.~~
~~(b) To specify hours of operation, waiting times for appointments in provider offices, or care provided after business hours.~~
~~(c) To require a certain number or certain types of participating providers per enrollees.~~
~~(d) To require any contract between the preferred provider plan and a participating provider to require the participating provider, when scheduling nonemergency care, to disclose to the enrollee the name of any provider participating in the care and to specify whether each provider participating in the care is a participating provider or not.~~
~~(e) To require the services of nonparticipating providers to be covered at the same rate as the services of participating providers if the preferred provider plan fails to comply with certain requirements.~~

As an alternative to the above, create a provision that would prohibit OCI from regulating PPO contracts beyond the plan agreement (the agreement with the purchaser of the plan).

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

609.20 **(4)** ~~The commissioner may promulgate a rule that requires a~~ A preferred provider plan ~~to~~ shall include in its provider directory, in substantially similar language and ~~in at least 11-point bold type conspicuously placed~~, the following notice:

IMPORTANT NOTICE

You are strongly encouraged to contact us to verify the status of the providers involved in your care including, for example, the anesthesiologist, radiologist, pathologist, facility, clinic, or laboratory, when scheduling appointments or elective procedures to determine whether each provider is a participating or nonparticipating provider. Such information may assist you in your selection of providers and will likely affect the level of copayment, deductible, and coinsurance applicable to the care you receive. The information contained in this directory may change during your plan year. Please contact [insert ~~800 and direct dial~~ phone number of insurer] to learn more about the participating providers in your network and the implications, including financial, if you decide to receive your care from nonparticipating providers.

SECTION ?. 609.20 (5) of the statutes is created to read:

609.20 **(5)** A defined network plan shall include in its marketing material, in substantially similar language and conspicuously placed, the following notice:

IMPORTANT NOTICE – YOUR BENEFITS MAY BE REDUCED WHEN NONPARTICIPATING PROVIDERS ARE USED. Please be aware that benefits for participating providers can be different than those used for non-participating providers. Your plan may actually reduce benefits when using non-participating providers To find out about your benefits, please read the benefit information found in ~~this document~~ these materials and in your plan documents, or you may call (Insert insurer telephone number).

SECTION ?. 609.20 (5m) of the statutes is created to read:

609.20 **(5m)** The Commissioner may not promulgate a rule that requires a defined network plan to provide any additional notice on nonparticipating provider limitations, other than the specific language prescribed in Section 609.20 (5).

~~**SECTION 5.** 609.21 of the statutes is created to read:~~

~~**609.21 Rules for limited scope plans. (1)** In this section, "limited scope plan" means a health care plan that provides limited-scope dental or vision benefits under a separate policy, certificate, or contract of insurance.~~

~~**(2)** The commissioner may not promulgate a rule that subjects a limited scope plan to s. 609.22, 609.24, 609.30, 609.32, 609.34, or 609.36.~~

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

609.22 (1m)(a) In order to meet the requirements of 609.22 (1), a Preferred Provider Plan shall ensure that at least one primary care provider, who may also provide the same services of an Obstetric and Gynecologic provider, is available to each enrollee.

treatment of the emergency medical condition.
2. As a result of the emergency, the enrollee was admitted to a nonparticipating provider for inpatient care.
(b) The coverage under par. (a) may be subject to any restrictions that govern payment to a participating provider for emergency medical services. The preferred provider plan shall pay the nonparticipating provider at the rate at which it pays a nonparticipating provider, after applying any copayments, deductibles, or other cost-sharing requirements that apply to a participating provider.
(c) A preferred provider plan is required to provide the coverage under par. (a) only with respect to services that are needed to stabilize, as defined in section 1867 of the federal Social Security Act, the enrollee's emergency medical condition.

~~SECTION 13. Nonstatutory provisions.~~
~~(1) STUDY ON USE OF PRIOR AUTHORIZATION TO DENY ACCESS. The office of the commissioner of insurance shall, through use of its complaint process, conduct a study on whether insurers that offer defined network plans, as defined in section 609.01 (1b) of the statutes, that are not preferred provider plans, as defined in section 609.01 (4) of the statutes, require prior authorization as part of the procedure for obtaining a standing referral to a specialist under section 609.22 (4) of the statutes and shall determine if requiring prior authorization is used for denying standing referrals to specialists without just cause and with such frequency as to indicate a general business practice. Within one year after the effective date of this subsection, the office of the commissioner of insurance shall submit to the appropriate standing committees of the legislature, in the manner provided under section 13.172 (3) of the statutes, a report of the results of the study that includes documentation in support of any determinations made.~~

SECTION 14. Initial applicability.
(1) COVERAGE OF SAME SERVICES AND EMERGENCY MEDICAL SERVICES. The renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes first apply to all of the following:
(a) Except as provided in paragraph (b), policies, plans, or contracts that are issued ~~or renewed~~ on the effective date of this paragraph.
(b) Policies, plans, or contracts covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with the renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes that are issued or renewed on the earlier of the following:
1. The day on which the collective bargaining agreement expires.
2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(may not renewed)

Add a section that provides an effective date on new policies sold on or after that date. It would also allow existing plans sold prior to the effective date to remain in effect until the termination of those specific policies.

(END)

except as provided in s. 609.20 3

SECTION ?. 609.22 (1m)(b) of the statutes is created to read:
609.22 (1m)(b) The Commissioner may not promulgate a rule that requires any additional access requirements on Preferred Provider Plans relative to 609.22 (1m)(a).

~~**SECTION 6.** 609.22 (4) (a) 2. of the statutes is renumbered 609.22 (4) (b).~~

~~**SECTION 7.** 609.22 (4) (a) 2m. of the statutes is created to read:~~
~~609.22 (4) (a) 2m. The commissioner may not promulgate a rule relating to the use of prior authorization requirements by insurers offering defined network plans that are not preferred provider plans to deny access, or standing referrals, to specialists.~~

limit to PPP's may not

~~**SECTION 8.** 609.22 (4) (a) 3. of the statutes is renumbered 609.22 (4) (c).~~

treat as new requirement in section

SECTION ?. 609.22 (9) of the statutes is created to read:
609.22 (9) Insurers shall not use utilization management, including a pre-authorization or similar methods, for denying access to nonparticipating providers.

SECTION 9. 609.35 of the statutes is renumbered 609.35 (2).

SECTION 10. 609.35 (1) of the statutes is created to read:
609.35 **(1)** In this section, a preferred provider plan ~~does not cover the same services when performed by a nonparticipating provider if any of the following applies~~ covers the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider when:
~~(a) The preferred provider plan does not cover a service when performed by a nonparticipating provider that it covers when performed by a participating provider.~~
~~(b) The preferred provider plan covers a service when performed by a nonparticipating provider that it covers when performed by a participating provider, but either of the following applies:~~ → paid by in-net

paid by in-net

~~1.~~ (a) The coinsurance differential between a participating and a nonparticipating provider for the service is ~~more than at least~~ 40 percent or less.
~~2.~~ (b) Coinsurance for the service when performed by a nonparticipating provider is ~~more than at least~~ 50 percent or less

SECTION 11. 609.82 of the statutes is renumbered 609.82 (1).

SECTION 12. 609.82 (2) of the statutes is created to read:
609.82 **(2)** (a) Except as provided in pars. (b) and (c), if a preferred provider plan provides coverage of emergency medical services, the preferred provider plan shall cover emergency medical services provided to an enrollee during the treatment of an emergency medical condition, as defined in s. 632.85 (1) (a), by a nonparticipating provider as though the services were provided by a participating provider, if any of the following applies:
1. The enrollee could not reasonably reach a participating provider for

meeting w/ me, Cathlene, Dan Schwartzer, Adam Peer, Joyce (tel), Richard West

PPP → not include limited scope plans

def of PPP → NWS (4) in this chapter PPP means

(move def to another place & change see # x-refs

* move to ch 600?

609.20(3) (except as provided in this chapter OCI may not promulgate a rule that regulates imposes requirements w/respect to agreement or contract between plan & provider

(beyond agreement between plan & insured)

add near 609.35(1) (or somewhere else re rule making 609.20??

OCI may not promulgate rules that regulate PPP re. limits on copays & deductibles or penalties

in 609.20 (3) requiring certain levels of add penalties

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB-4275/P1
CMH&PJK:jld:jf

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT ***to renumber*** 609.22 (4) (a) 2., 609.22 (4) (a) 3., 609.35 and 609.82; ***to amend*** 601.47 (3); and ***to create*** 601.47 (2m), 609.20 (3), 609.20 (4), 609.21, 609.22 (4) (a) 2m., 609.35 (1) and 609.82 (2) of the statutes; **relating to:** defined network plans.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a later version.

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

SECTION 1. 601.47 (2m) of the statutes is created to read:

601.47 **(2m)** The commissioner shall prepare and publish a guide to out–of–network coverage for defined network plans and distribute it in a manner that the commissioner determines. The cost of publication and distribution may be paid from the appropriation under s. 20.145 (1) (g).

SECTION 2. 601.47 (3) of the statutes is amended to read:

601.47 **(3)** FREE DISTRIBUTION. The commissioner may furnish free copies of the publications prepared under subs. (1) ~~and~~, (2), and (2m) to public officers and libraries in this state and elsewhere. The cost of free distribution shall be charged to the appropriation under s. 20.145 (1) (g).

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

609.20 **(3)** The commissioner may not promulgate a rule relating to a preferred provider plan for any of the following purposes:

(a) To require a specified availability within geographical areas.

(b) To specify hours of operation, waiting times for appointments in provider offices, or care provided after business hours.

(c) To require a certain number or certain types of participating providers per enrollees.

(d) To require any contract between the preferred provider plan and a participating provider to require the participating provider, when scheduling nonemergency care, to disclose to the enrollee the name of any provider participating in the care and to specify whether each provider participating in the care is a participating provider or not.

(e) To require the services of nonparticipating providers to be covered at the same rate as the services of participating providers if the preferred provider plan fails to comply with certain requirements.

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

609.20 **(4)** The commissioner may promulgate a rule that requires a preferred provider plan to include in its provider directory, in substantially similar language and in at least 11-point bold type, the following notice:

IMPORTANT NOTICE

You are strongly encouraged to contact us to verify the status of the providers involved in your care including, for example, the anesthesiologist, radiologist, pathologist, facility, clinic, or laboratory, when scheduling appointments or elective procedures to determine whether each provider is a participating or nonparticipating provider. Such information may assist you in your selection of providers and will likely affect the level of copayment, deductible, and coinsurance applicable to the care you receive. The information contained in this directory may change during your plan year. Please contact [insert 800 and direct dial phone number of insurer] to learn more about the participating providers in your network and the implications, including financial, if you decide to receive your care from nonparticipating providers.

SECTION 5. 609.21 of the statutes is created to read:

609.21 Rules for limited scope plans. (1) In this section, "limited scope plan" means a health care plan that provides limited–scope dental or vision benefits under a separate policy, certificate, or contract of insurance.

(2) The commissioner may not promulgate a rule that subjects a limited scope plan to s. 609.22, 609.24, 609.30, 609.32, 609.34, or 609.36.

SECTION 6. 609.22 (4) (a) 2. of the statutes is renumbered 609.22 (4) (b).

SECTION 7. 609.22 (4) (a) 2m. of the statutes is created to read:

609.22 **(4)** (a) 2m. The commissioner may not promulgate a rule relating to the use of prior authorization requirements by insurers offering defined network plans that are not preferred provider plans to deny access, or standing referrals, to specialists.

SECTION 8. 609.22 (4) (a) 3. of the statutes is renumbered 609.22 (4) (c).

SECTION 9. 609.35 of the statutes is renumbered 609.35 (2).

SECTION 10. 609.35 (1) of the statutes is created to read:

609.35 **(1)** In this section, a preferred provider plan does not cover the same services when performed by a nonparticipating provider if any of the following applies:

(a) The preferred provider plan does not cover a service when performed by a nonparticipating provider that it covers when performed by a participating provider.

(b) The preferred provider plan covers a service when performed by a nonparticipating provider that it covers when performed by a participating provider, but either of the following applies:

1. The coinsurance differential between a participating and a nonparticipating provider for the service is more than 40 percent.

2. Coinsurance for the service when performed by a nonparticipating provider is more than 50 percent.

SECTION 11. 609.82 of the statutes is renumbered 609.82 (1).

SECTION 12. 609.82 (2) of the statutes is created to read:

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

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

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

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

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

SECTION 13. Nonstatutory provisions.

(1) STUDY ON USE OF PRIOR AUTHORIZATION TO DENY ACCESS. The office of the commissioner of insurance shall, through use of its complaint process, conduct a study on whether insurers that offer defined network plans, as defined in section 609.01 (1b) of the statutes, that are not preferred provider plans, as defined in section 609.01 (4) of the statutes, require prior authorization as part of the procedure for obtaining a standing referral to a specialist under section 609.22 (4) of the statutes and shall determine if requiring prior authorization is used for denying standing referrals to specialists without just cause and with such frequency as to indicate a general business practice. Within one year after the effective date of this subsection, the office of the commissioner of insurance shall submit to the appropriate standing committees of the legislature, in the manner provided under section 13.172 (3) of the statutes, a report of the results of the study that includes documentation in support of any determinations made.

SECTION 14. Initial applicability.

(1) COVERAGE OF SAME SERVICES AND EMERGENCY MEDICAL SERVICES. The renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes first apply to all of the following:

(a) Except as provided in paragraph (b), policies, plans, or contracts that are issued or renewed on the effective date of this paragraph.

(b) Policies, plans, or contracts covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with the renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(END)

Insert 6-13

*LPS - inserts out of order

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INSERT 2–5PJK (to ins 2-5)

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

(END OF INSERT 2–5PJK)

INSERT 2–22

SECTION 1. 609.20 (4) of the statutes is created to read:

609.20 **(4)** The commissioner may not promulgate a rule that requires a defined network plan to provide notice about nonparticipating provider limitations in addition to the notice required under s. 609.23 (1).

INS cmh1 (to ins 2-22)

SECTION 2. 609.22 (9) of the statutes is created to read:

609.22 **(9)** PROHIBITION ON USE OF UTILIZATION MANAGEMENT. An insurer offering a preferred provider plan may not use utilization management techniques, including prior authorization requirements or similar methods, to deny access to nonparticipating providers.

SECTION 3. 609.23 of the statutes is created to read:

609.23 Required notices. (1) DEFINED NETWORK PLANS. A defined network plan shall include in its marketing materials, in substantially similar language, the following notice:

****NOTE: I left "conspicuously placed" out of this language, too. OK?

IMPORTANT NOTICE

move to next line

YOUR BENEFITS MAY BE REDUCED WHEN NONPARTICIPATING PROVIDERS ARE USED

Please be aware that your benefits when you use participating providers may be different from the benefits when you use

nonparticipating providers. Your plan may actually reduce your benefits when you use nonparticipating providers. To find out about your benefits, please read the benefit information found in these materials and in your plan documents, or you may call [insert phone number of insurer].

****NOTE: I did not include a reference to the guide prepared by OCI because, unless one has been prepared already, the effective date for this notice would have to be delayed. A reference to the guide, when it is prepared, may be included by insurers in this notice, however, because of the "substantially similar" language.

(2) PREFERRED PROVIDER PLANS. A preferred provider plan shall NO ¶

(END OF INSERT 2-22)

INSERT 6-13

(#) ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. If an insurance policy, plan, or certificate that is issued by a preferred provider plan and that is in effect on the effective date of this subsection, or a contract that is in effect on the effective date of this subsection between a provider and a preferred provider plan, contains a provision that is inconsistent with the treatment of section 609.22 (1m) (a) of the statutes, the treatment of section 609.22 (1m) (a) of the statutes first applies to that policy, plan, certificate, or contract on the date on which it is renewed.

(#) PRIOR AUTHORIZATION REQUIREMENTS. If an insurance policy, plan, or certificate that is issued by a preferred provider plan and that is in effect on the effective date of this subsection, or a contract that is in effect on the effective date of this subsection between a provider and a preferred provider plan, contains a provision that is inconsistent with the treatment of section 609.22 (9) of the statutes, the treatment of section 609.22 (9) of the statutes first applies to that policy, plan, certificate, or contract on the date on which it is renewed.

(END OF INSERT 6-13)

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SECTION 1. 51.20 (7) (am) of the statutes is amended to read:

51.20 **(7)** (am) A subject individual may not be examined, evaluated or treated for a nervous or mental disorder pursuant to a court order under this subsection unless the court first attempts to determine whether the person is an enrollee of a health maintenance organization, limited service health organization or preferred provider plan, as defined in s. ~~609.01~~ 600.03 (37m), and, if so, notifies the organization or plan that the subject individual is in need of examination, evaluation or treatment for a nervous or mental disorder.

History: 1975 c. 430; 1977 c. 26, 29; 1977 c. 187 ss. 42, 43, 134, 135; 1977 c. 428 ss. 29 to 65, 115; 1977 c. 447, 449; Sup. Ct. Order, 83 Wis. 2d xiii; 1979 c. 32, 89; Sup. Ct. Order, eff. 1–1–80; 1979 c. 110 s. 60 (1); 1979 c. 175 s. 53; 1979 c. 300, 336, 356; 1981 c. 20, 367; 1981 c. 390 s. 252; 1983 a. 27, 219; 1983 a. 474 ss. 2 to 9m, 14; 1985 a. 29 ss. 1067 to 1071, 3200 (56), 3202 (56); 1985 a. 139, 176, 321, 332; 1987 a. 27; Sup. Ct. Order, 141 Wis. 2d xiii (1987); 1987 a. 366, 394, 403; 1989 a. 31, 334; 1993 a. 98, 196, 227, 316, 451, 474; 1995 a. 77, 201, 268, 292, 440; Sup. Ct. Order No. 96–08, 207 Wis. 2d xv (1997); 1997 a. 35, 130, 237, 283; 1999 a. 83, 89, 162; 2001 a. 16 ss. 1966i to 1966n, 4034ze to 4034zh; 2001 a 38, 61, 109; 2003 a. 33, 50, 326; 2005 a. 22.

SECTION 2. 149.10 (8m) of the statutes is amended to read:

149.10 **(8m)** "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~ 600.03 (37m).

History: 1997 a. 27 ss. 3014 to 3024, 4814, 4817 to 4824; Stats. 1997 s. 149.10; 1999 a. 9; 2001 a. 38; 2003 a. 33; 2005 a. 74.

SECTION 3. 150.84 (5) of the statutes is amended to read:

150.84 **(5)** "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~ 600.03 (37m), as defined in s. 609.01 (3),

History: 1991 a. 250; 1993 a. 27; 1995 a. 27; 1997 a. 35; 1999 a. 9; 2005 a. 22.

SECTION 4. 600.03 (23g) (a) of the statutes is amended to read:

600.03 **(23g)** (a) Contracts with a health maintenance organization, limited service health organization or preferred provider plan, ~~as defined in s. 609.01,~~ to provide health care services.

(end ins 1-5)

History: 1971 c. 260; 1973 c. 22; Sup. Ct. Order, 67 Wis. 2d 585, 776 (1975); 1975 c. 223, 371, 374, 375, 421; 1977 c. 339; 1979 c. 89 ss. 383, 543; 1979 c. 102 ss. 49 to 53, 236 (22); 1979 c. 177; 1981 c. 38, 82; 1983 a. 120, 189, 274, 358; 1985 a. 29; 1987 a. 167, 247; 1989 a. 23, 31; 1989 a. 187 s. 29; 1993 a. 201; 1995 a. 225; 1999 a. 30; 2001 a. 65; 2003 a. 261.

as defined in s. 609.01 (2),

Insert 2–5

SECTION 5. 609.01 (4) of the statutes is renumbered 600.03 (37m).

SECTION 6. 609.01 (4g) of the statutes is created to read:

609.01 **(4g)** Notwithstanding s. 600.03 (37m), "preferred provider plan" means a health benefit plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, without referral and for consideration other than predetermined periodic fixed payments, coverage of either comprehensive health care services or a limited range of health care services, regardless of whether the health care services are performed by participating or nonparticipating providers.

SECTION 7. 609.20 (3) of the statutes is created to read:

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

Insert 2-5 PJK →

(end ins 2-5)

Insert cmh1 (to Insert 2–22)

, for the provision of obstetric and gynecologic services

SECTION 8. 609.22 (1m) of the statutes is created to read:

609.22 **(1m)** ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. (a) A preferred provider plan meets the requirements listed in sub. (1) if the preferred provider plan ensures that each enrollee has access to at least one primary provider, who may also provide the services of an obstetric and gynecologic provider.

(b) Except as provided in this section and in s. 609.20, the commissioner may not promulgate a rule that requires any additional access standards for preferred provider plans.

(end ins cmh1 to Ins 2-22)

relative to access to obstetric and gynecologic services

Insert 5–25

SECTION 9. 611.67 (1) (d) of the statutes is repealed.

SECTION 10. 628.36 (2m) (a) 3. of the statutes is repealed.

SECTION 11. 632.745 (15) of the statutes is amended to read:

632.745 **(15)** "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers health benefit plans covering individuals in this state or eligible employees of one or more employers in this state. The term includes a health maintenance organization, a preferred provider plan, ~~as defined in s. 609.01 (4),~~ an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

History: 1995 a. 289, 453; 1997 a. 27; 1999 a. 9; 2001 a. 38.

SECTION 12. 632.84 (3) of the statutes is amended to read:

632.84 **(3)** EXCEPTIONS. This section does not apply to a health maintenance organization, limited service health organization or preferred provider plan, ~~as defined in s. 609.01~~.

History: 1987 a. 156, 403; 1989 a. 31.

SECTION 13. 632.86 (1) (a) of the statutes is amended to read:

632.86 **(1)** (a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a), except that the term does not include coverage under a health maintenance organization, as defined in s. 609.01 (2), a limited service health organization, as defined in s. 609.01 (3), a preferred provider plan, ~~as defined in s. 609.01 (4),~~ or a sickness care plan operated by a cooperative association organized under ss. 185.981 to 185.985.

History: 1991 a. 70.

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

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

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672; 2001 a. 16, 82.

SECTION 15. 635.02 (8) of the statutes is amended to read:

635.02 **(8)** "Small employer insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employees of one or more small employers in this state, or that sells 3 or more individual health benefit plans to a small employer, covering eligible employees of the small employer. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, ~~as defined in s. 609.01 (4),~~ and an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, but does not include a limited service health organization, as defined in s. 609.01 (3).

History: 1991 a. 39, 250; 1993 a. 112; 1995 a. 289, 453; 1997 a. 27; 2001 a. 16.

(end ins 5-25)

2-14

Dan Schwartzer

for 609.22 (1m) need access to primary care provider in each enrollee "consistent with normal practices and standards in the geographic area"

+ add "consistent with" language to ob/gyn provision, too

2005–2006 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

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Current law contains various provisions that apply specifically to defined network plans and preferred provider plans. A defined network plan is a hospital or medical policy or certificate that requires, or provides incentives for, enrollees to obtain health care services from providers that are managed, owned, under contract with, or employed by the insurer offering the policy or certificate (participating providers). Specifically excluded, however, are limited–scope dental or vision plans. A health maintenance organization is an example of a defined network plan. A preferred provider plan, which covers either comprehensive or limited health care services provided by either participating or nonparticipating providers, is also a defined network plan, except for one that is a limited–scope dental or vision plan, because obtaining services from participating providers usually requires lower levels of cost–sharing than obtaining services from nonparticipating providers. This bill makes various changes relating to defined network plans and preferred provider plans, including the following:

1. Changes the definition of a preferred provider plan, with regard to defined network plans, from an insurance contract providing coverage of health care expenses to any hospital or medical policy or certificate.

2. Prohibits the commissioner of insurance (commissioner) from doing any of the following: regulating contracts between a preferred provider plan and its participating providers; establishing limits or levels for copayments, deductibles, or penalties imposed by preferred provider plans; or requiring a defined network plan to provide notice about nonparticipating provider limitations.

3. Clarifies that a preferred provider plan covers the same service when it is performed by a nonparticipating provider that the plan covers when it is performed by a participating provider if either the coinsurance differential is 40 percent or less, or the coinsurance is 50 percent or less.

4. Establishes that preferred provider plans have complied with certain access requirements if the number of primary care providers available is consistent with normal practices and standards in the geographic area and if each female enrollee has access to at least one primary care provider who provides obstetric and gynecologic services and prohibits additional requirements by rule.

5. Requires a defined network plan to include a notice in its marketing materials to alert a prospective enrollee that benefits may be reduced when services are obtained from a nonparticipating provider and prohibits the commissioner from promulgating rules that require additional notice about nonparticipating provider limitations.

6. Requires a preferred provider plan to include in its provider directory a notice that encourages an enrollee to contact the preferred provider plan to verify whether a provider involved in his or her care is a participating or nonparticipating provider, since that may affect the enrollee's level of cost–sharing.

7. Requires the commissioner to publish and distribute a guide that describes out–of–network coverage for all defined network plans.

8. Prohibits a preferred provider plan from using utilization management techniques, including prior authorization requirements, to deny access to nonparticipating providers.

9. Generally, requires a preferred provider plan that covers emergency services to cover treatment of an emergency medical condition by a nonparticipating provider as though the services were provided by a participating provider if: a) the enrollee could not reasonably reach a participating provider for the treatment, or b) as a result of the emergency, the enrollee was admitted to a nonparticipating provider for inpatient care.

(END OF INSERT A)

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB-4275/P2
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PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT ***to repeal*** 611.67 (1) (d) and 628.36 (2m) (a) 3.; ***to renumber*** 609.01 (4), 609.35 and 609.82; ***to amend*** 51.20 (7) (am), 149.10 (8m), 150.84 (5), 600.03 (23g) (a), 601.47 (3), 632.745 (15), 632.84 (3), 632.86 (1) (a), 632.895 (14) (d) 3. and 635.02 (8); and ***to create*** 601.47 (2m), 609.01 (4g), 609.20 (3), 609.20 (4), 609.22 (1m), 609.22 (9), 609.23, 609.35 (1) and 609.82 (2) of the statutes; **relating to:** ~~defined network plans.~~

Analysis by the Legislative Reference Bureau

~~This is a preliminary draft. An analysis will be provided in a later version.~~

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

SECTION 1. 51.20 (7) (am) of the statutes is amended to read:

51.20 **(7)** (am) A subject individual may not be examined, evaluated or treated for a nervous or mental disorder pursuant to a court order under this subsection unless the court first attempts to determine whether the person is an enrollee of a

health maintenance organization, as defined in s. 609.01 (2), limited service health organization, as defined in s. 609.01 (3), or preferred provider plan, as defined in s. ~~609.01~~ 600.03 (37m), and, if so, notifies the organization or plan that the subject individual is in need of examination, evaluation or treatment for a nervous or mental disorder.

SECTION 2. 149.10 (8m) of the statutes is amended to read:

149.10 **(8m)** "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~ 600.03 (37m).

SECTION 3. 150.84 (5) of the statutes is amended to read:

150.84 **(5)** "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~ 600.03 (37m).

SECTION 4. 600.03 (23g) (a) of the statutes is amended to read:

600.03 **(23g)** (a) Contracts with a health maintenance organization, as defined in s. 609.01 (2), limited service health organization, as defined in s. 609.01 (3), or preferred provider plan~~, as defined in s. 609.01~~, to provide health care services.

SECTION 5. 601.47 (2m) of the statutes is created to read:

601.47 **(2m)** The commissioner shall prepare and publish a guide that describes out–of–network coverage for all defined network plans and distribute it in a manner that the commissioner determines. The cost of publication and distribution may be paid from the appropriation under s. 20.145 (1) (g).

SECTION 6. 601.47 (3) of the statutes is amended to read:

601.47 **(3)** FREE DISTRIBUTION. The commissioner may furnish free copies of the publications prepared under subs. (1) ~~and~~, (2), and (2m) to public officers and libraries in this state and elsewhere. The cost of free distribution shall be charged to the appropriation under s. 20.145 (1) (g).

insert 3-1

SECTION 7. 609.01 (4) of the statutes is renumbered 600.03 (37m).

SECTION 8. 609.01 (4g) of the statutes is created to read:

609.01 **(4g)** Notwithstanding s. 600.03 (37m), "preferred provider plan" means a health benefit plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrollees, without referral and for consideration other than predetermined periodic fixed payments, coverage of either comprehensive health care services or a limited range of health care services, regardless of whether the health care services are performed by participating or nonparticipating providers.

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

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

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

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

609.20 **(4)** The commissioner may not promulgate a rule that requires a defined network plan to provide notice about nonparticipating provider limitations in addition to the notice required under s. 609.23 (1).

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

insert 3-22

609.22 **(1m)** ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. (a) To satisfy the requirements in sub. (1), a preferred provider plan shall ensure that, for the provision of obstetric and gynecologic services, each female enrollee has access to at least one primary care provider who provides those services.

, consistent with normal practices and standards in the geographic area,

(b) Except as provided in this section and in s. 609.20, the commissioner may not promulgate a rule that imposes any additional requirements for preferred provider plans relative to access to obstetric and gynecologic services.

SECTION 12. 609.22 (9) of the statutes is created to read:

609.22 **(9)** PROHIBITION ON USE OF UTILIZATION MANAGEMENT. An insurer offering a preferred provider plan may not use utilization management techniques, including prior authorization requirements or similar methods, to deny access to nonparticipating providers.

SECTION 13. 609.23 of the statutes is created to read:

609.23 Required notices. (1) DEFINED NETWORK PLANS. A defined network plan shall include in its marketing materials, in substantially similar language, the following notice:

****NOTE: I left "conspicuously placed" out of this language, too. OK?

IMPORTANT NOTICE

YOUR BENEFITS MAY BE REDUCED WHEN

NONPARTICIPATING PROVIDERS ARE USED

Please be aware that your benefits when you use participating providers may be different from the benefits when you use nonparticipating providers. Your plan may actually reduce your benefits when you use nonparticipating providers. To find out about your benefits, please read the benefit information found in these materials and in your plan documents, or you may call [insert phone number of insurer].

****NOTE: I did not include a reference to the guide prepared by OCI because, unless one has been prepared already, the effective date for this notice would have to be delayed. A reference to the guide, when it is prepared, may be included by insurers in this notice, however, because of the "substantially similar" language.

(2) PREFERRED PROVIDER PLANS. A preferred provider plan shall include in its provider directory, in substantially similar language, the following notice:

IMPORTANT NOTICE

You are strongly encouraged to contact us to verify the status of the providers involved in your care including, for example, the anesthesiologist, radiologist, pathologist, facility, clinic, or laboratory, when scheduling appointments or elective procedures to determine whether each provider is a participating or nonparticipating provider. Such information may assist you in your selection of providers and will likely affect the level of copayment, deductible, and coinsurance applicable to the care you receive. The information contained in this directory may change during your plan year. Please contact [insert phone number of insurer] to learn more about the participating providers in your network and the implications, including financial, if you decide to receive your care from nonparticipating providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

632.745 **(15)** "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers health benefit plans covering individuals in this state or eligible employees of

one or more employers in this state. The term includes a health maintenance organization, a preferred provider plan, ~~as defined in s. 609.01 (4),~~ an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

SECTION 21. 632.84 (3) of the statutes is amended to read:

632.84 **(3)** EXCEPTIONS. This section does not apply to a health maintenance organization, as defined in s. 609.01 (2), limited service health organization, as defined in s. 609.01 (3), or preferred provider plan~~, as defined in s. 609.01~~.

SECTION 22. 632.86 (1) (a) of the statutes is amended to read:

632.86 **(1)** (a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a), except that the term does not include coverage under a health maintenance organization, as defined in s. 609.01 (2), a limited service health organization, as defined in s. 609.01 (3), a preferred provider plan, ~~as defined in s. 609.01 (4),~~ or a sickness care plan operated by a cooperative association organized under ss. 185.981 to 185.985.

SECTION 23. 632.895 (14) (d) 3. of the statutes is amended to read:

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

SECTION 24. 635.02 (8) of the statutes is amended to read:

635.02 **(8)** "Small employer insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employees of one or more small employers in this state, or that sells 3 or more individual health benefit plans to a small employer, covering eligible employees of the small employer.

The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, ~~as defined in s. 609.01 (4),~~ and an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, but does not include a limited service health organization, as defined in s. 609.01 (3).

SECTION 25. Initial applicability.

(1) COVERAGE OF SAME SERVICES AND EMERGENCY MEDICAL SERVICES. The renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes first apply to all of the following:

(a) Except as provided in paragraph (b), policies, plans, or contracts that are issued or renewed on the effective date of this paragraph.

(b) Policies, plans, or contracts covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with the renumbering of sections 609.35 and 609.82 of the statutes and the creation of sections 609.35 (1) and 609.82 (2) of the statutes that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(2) ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. If an insurance policy, plan, or certificate that is issued by a preferred provider plan and that is in effect on the effective date of this subsection, or a contract that is in effect on the effective date of this subsection between a provider and a preferred provider plan, contains a provision that is inconsistent with the treatment of section 609.22 (1m) (a) of the statutes, the treatment of section 609.22 (1m) (a) of the statutes first applies to that policy, plan, certificate, or contract on the date on which it is renewed.

(3) PRIOR AUTHORIZATION REQUIREMENTS. If an insurance policy, plan, or certificate that is issued by a preferred provider plan and that is in effect on the effective date of this subsection, or a contract that is in effect on the effective date of this subsection between a provider and a preferred provider plan, contains a provision that is inconsistent with the treatment of section 609.22 (9) of the statutes, the treatment of section 609.22 (9) of the statutes first applies to that policy, plan, certificate, or contract on the date on which it is renewed.

(END)

INSERT 1–6

relating clause

1 prohibiting certain rules related to defined network plans and preferred
2 provider plans, requiring defined network plans and preferred provider plans to
3 provide certain notices, requiring the commissioner of insurance to publish a guide
4 describing out–of–network coverage for all defined network plans, and other
5 miscellaneous provisions related to preferred provider plans.

(END OF INSERT 1–6)

INSERT 3–1

6 **SECTION 1.** 609.01 (4) of the statutes is renumbered 600.03 (37m) and amended
7 to read:
8 600.03 **(37m)** "Preferred provider plan" means a health care plan, as defined
9 in s. 628.36 (2) (a) 1., that is offered by an organization established under ch. 185, 611,
10 613, or 614 or issued a certificate of authority under ch. 618 and that makes available
11 to its enrollees, without referral and for consideration other than predetermined
12 periodic fixed payments, coverage of either comprehensive health care services or a
13 limited range of health care services, regardless of whether the health care services
14 are performed by participating, as defined in s. 609.01 (3m), or nonparticipating
15 providers, as defined in s. 609.01 (5m).

History: 1985 a. 29; 1989 a. 23; 1997 a. 237; 2001 a. 16.

(END OF INSERT 3–1)

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Current law contains various provisions that apply specifically to defined network plans and preferred provider plans. A defined network plan is a hospital or medical policy or certificate that requires, or provides incentives for, enrollees to obtain health care services from providers that are managed, owned, under contract with, or employed by the insurer offering the policy or certificate (participating providers). Specifically excluded, however, are limited–scope dental or vision plans. A health maintenance organization is an example of a defined network plan. A preferred provider plan, which covers either comprehensive or limited health care services provided by either participating or nonparticipating providers, is also a defined network plan, except for one that is a limited–scope dental or vision plan, because obtaining services from participating providers usually requires lower levels of cost–sharing than obtaining services from nonparticipating providers. This bill makes various changes relating to defined network plans and preferred provider plans, including the following:

1. Changes the definition of a preferred provider plan so that the requirements pertaining to preferred provider plans do not apply to preferred provider plans that are limited–scope dental or vision plans.

2. Prohibits the commissioner of insurance (commissioner) from promulgating a rule that regulates contracts between a preferred provider plan and its participating providers or that establishes limits or levels for copayments, deductibles, or penalties imposed by preferred provider plans.

3. Clarifies that a preferred provider plan covers the same service when it is performed by a nonparticipating provider that the plan covers when the service is performed by a participating provider if either the coinsurance differential paid by an enrollee is 40 percent or less or the coinsurance paid by an enrollee is 50 percent or less.

4. Establishes that preferred provider plans have complied with certain access requirements if the number of primary care providers available is consistent with normal practices and standards in the geographic area and if each female enrollee has access to at least one primary care provider who provides obstetric and gynecologic services and prohibits additional requirements by rule.

5. Requires a defined network plan to include a notice in its marketing materials to alert a prospective enrollee that benefits may be reduced when services are obtained from a nonparticipating provider and prohibits the commissioner from promulgating rules that require additional notice about nonparticipating provider limitations.

6. Requires a preferred provider plan to include in its provider directory a notice that encourages an enrollee to contact the preferred provider plan to verify whether a provider involved in his or her care is a participating or nonparticipating provider, since that may affect the enrollee's level of cost–sharing.

7. Requires the commissioner to publish and distribute a guide that describes out–of–network coverage for all defined network plans.

Insert A cont'd 2 of 2

8. Prohibits a preferred provider plan from using utilization management techniques, including prior authorization requirements, to deny access to nonparticipating providers.

9. Generally, requires a preferred provider plan that covers emergency services to cover treatment of an emergency medical condition by a nonparticipating provider as though the services were provided by a participating provider if: a) the enrollee could not reasonably reach a participating provider for the treatment; or b) as a result of the emergency, the enrollee was admitted to a nonparticipating provider for inpatient care.

(END OF INSERT A)

2005–2006 DRAFTING INSERT
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LRB–4275/1ins
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Insert 3–22

(a) A preferred provider plan meets all of the requirements in sub. (1) if the preferred provider plan ~~ensures that the number of primary care providers available to each enrollee is~~ consistent with normal practices and standards in the geographic area.

~~1. Ensures that at least one primary care provider is available.~~

1. Ensures that each enrollee has access, to at least one primary care provider.

2. Ensures

(end of ins 3-22)

Northrop, Lori

From: Wenzlaff, Tyler
Sent: Monday, February 20, 2006 9:37 AM
To: LRB.Legal
Subject: Draft Review: LRB 05-4275/1 Topic: Defined network plans

Please Jacket LRB 05-4275/1 for the ASSEMBLY. This is a rush, thank you.

Tyler Wenzlaff
Legislative Assistant
Rep. Nischke
608-266-8580