

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:

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Typed</u>	<u>Proofed</u>	<u>Submitted</u>	<u>Jacketed</u>	<u>Required</u>
/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	

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	02/14/2006 chanaman 02/15/2006	02/15/2006	02/15/2006	_____ _____ _____	02/15/2006	02/20/2006	

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/P2	pkahler 02/03/2006 chanaman 02/10/2006	jdyer 02/10/2006 <i>11 kjf</i> <i>2/15</i>	rschluet 02/10/2006	_____	sbasford 02/10/2006		
			<i>JG</i> <i>2/15</i>	<i>JG</i> <i>2/15</i>			

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/P1	chanaman 01/19/2006	jdyer 01/20/2006	jfrantze 01/20/2006		Inorthro 01/20/2006		

FE Sent For:

1/2 2/10 jw
[Signature]
<END>
2106 pb

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/P1	chanaman 01/19/2006	lrb_editor					
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			<i>Jb</i>	<i>J/d</i>			
		<i>/P1 1/20 jcd</i>	<i>1/20</i>	<i>1/20</i>			

FE Sent For:

<END>



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

3
Delete the inclusion of limited scope plans
Delete 9.01 (10m) *prohibit rule*

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

1 Delete the disclosure language within the regulation and have the OCI develop a consumers guide to out of network coverages for defined network plans, 2

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. *study & no rule*

Compromise on additional "substantial coverage" provisions

Agree to a coinsurance differential of 40%, but delete the deductible and co-pay requirements and either: 1

Delete the disclosure language within the regulation and have the OCI develop a consumers guide to out of network coverages for defined network plans, *see 9.27*

Or,

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

4 Delete the inclusion of PPP's in Access Standards

Delete 9.32 (2)(a) & (2)(b) *no rules*

Delete the inclusion of PPP's in new provisions of Access Standards

Delete 9.32 (2)(c), (2)(e) & ~~(2)(f)~~ *→ 9.33*

5 Compromise on Provider Directories and Appendix D

Change 9.32 (2)(d) to allow for substantially similar language ✓

7 Agree to Emergency Services Provision

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

*(f) so org cover to point of stabilization
PPP →*

609.35
① define
cover the same services

means: nonp

does not cover same services if:

- ① Service not covered
- ② service 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 covered pay > 50% (PPP must pay for at least 50%)

see 9.25(1)

(a) + (b)

③ re to old rope plan

② ~~revised (state)~~
+ have OCI develop consumer guide

OCI way
lets us not provide rules that subj
is p to

609.22

609.24

609.30

609.32

609.34

~~609.35~~

9.92



4

prohibit OCI ~~to~~ ^{for} ~~under~~ ^{require}
~~regarding~~

requiring that contract ~~to~~ ^{for}
 part provides specific ~~terms~~ ^{terms}
 hrs of operation

5

geo location
 wa

Appen D

if OCI requires a state that,
 may not require the exact
 language
 (allow most similar)
 (which is App E)

6

study on search & access
 & prohibit OCI from doing rule





State of Wisconsin
2005 - 2006 LEGISLATURE

LRB-4275/P1

PJK&CMH:.....

MONDAY

g
L Jld
+PJK

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

LPS -
please
check out
refs

Gen

1 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:

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

3 601.47 (2m) The commissioner[✓] shall prepare and publish a guide to
4 out-of-network[✓] coverage for defined network plans and distribute it in a manner
5 that the commissioner determines. The cost of publication and distribution may be
6 paid from the appropriation under s. 20.145 (1) (g).[✓]

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

8 601.47 (3) FREE DISTRIBUTION. The commissioner may furnish free copies of the
9 publications[✓] prepared under subs. (1) and, (2), and (2m)[✓] to public officers and

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

History: 1971 c. 125; 1979 c. 102 ss. 75, 236 (6); 2001 a. 10

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

4 609.20 (3) The commissioner may not promulgate a rule relating to a preferred
5 provider plan for any of the following purposes:

6 (a) To require availability ^{a specified} in ^{specified} geographical areas. *within*

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

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

10 (d) To require any contract ^{that schedules} nonemergency care ^{to specify the}
11 name of any ^{person} participating in the care and to specify whether each ^{person}
12 participating in the care is a participating provider or not. *disclose to the enrollee*
provider

***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??

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

14 609.21 Rules for limited scope plans. The commissioner may not
15 promulgate a rule that subjects a limited scope plan to ss. 609.22, 609.24, 609.30,
16 609.32, 609.34, or 609.36. *Insert 2-12*
Insert 2-14

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

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

19 609.35 (1) In this section, a preferred provider plan does not cover ~~a service~~ if
20 any of the following ^{applies} apply:

21 (a) The preferred provider plan does not cover ~~the service~~. *Insert 2-19*
Insert 2-21

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

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

6 →

(END)

Insert 3-5 ✓

2005-2006 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-4275/P1ins
PJK:.....

INSERT 2-10

1 ^{not} between the preferred provider plan and a participating provider to require the
2 participating provider, when scheduling ^{NO} ~~PH~~

(END OF INSERT 2-10)

INSERT 2-12

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

(END OF INSERT 2-12)

INSERT 2-14

6 ^{not} (1) In this section, "limited scope plan" means a health care plan that provides
7 limited-scope dental or vision benefits under a separate policy, certificate, or
8 contract of insurance.

9 ^{CH} (2) ^{NO} ~~PH~~

(END OF INSERT 2-14)

~~INSERT 2-16~~

10 SECTION 1. 609.20 (4) of the statutes is created to read:
11 609.20 (4) The commissioner may promulgate a rule that requires a preferred
12 provider plan to include in its provider directory, in substantially similar language
13 and in at least 11-point bold type, the following notice:

INSERT A
(TO INS 2-12)

INSERT 2-16

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

INS. 2-16
CONT

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

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

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

(END OF INSERT 2-16)

INSERT 2-19

7 the same services when performed by a nonparticipating provider

(END OF INSERT 2-19)

INSERT 2-21

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

(END OF INSERT 2-21)

INSERT 3-5

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

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

15 2. Coinsurance for the service when performed by a nonparticipating provider
16 is ^{more than} 50 percent ~~or more~~.

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



INS 3-5
CORT

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

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

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

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

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

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

20 **SECTION 7. Nonstatutory provisions.**

21 (1) **STUDY ON USE OF PRIOR AUTHORIZATION TO DENY ACCESS.** The office of the
22 commissioner of insurance shall, through use of its complaint process, conduct a
23 study on whether insurers that offer defined network plans, as defined in section
24 609.01 of the statutes, that are not preferred provider plans, as defined in section
25 609.01 (4) of the statutes, require prior authorization as part of the procedure for

24

(1b)
letter



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

9 **SECTION 8. Initial applicability.**

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

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

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

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

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

Insert A (to INS 2-12)

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 9.349.32 (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 providers 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.

12-point in bold font

justify

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).

ok published

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.

more current defo create new one

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,~~ *out* 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, 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.

notice regarding benefit reduction

OCI may not prom rule that requires additional (add ref to OCI guide + phone no)

Obst lead enrollee has access to at least

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.

(copy 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 otherwise provided in the statute
+ c 609.20 3*

SECTION 7. 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.

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

SECTION 9. 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:~~

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

treat as new requirement in section

limit to

PPP's way out

paid by insured

paid by insured

or less

PPP → not include limited scope plans

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

(move def to another place
& change
sec # X-refs
* move to ch 600?)

609.20(3)

(except as provided in this chapter OCF 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 re 609.20?)

OCF may not ~~prom~~ promulgate a rule that ~~establish~~
~~limits~~ limits on copays & deductibles
or penalties

in
609.20
(3)

limits on copays & deductibles
or penalties
requiring certain levels of
add penalties



Meeting w/ me, Catalano, Ben Schwartz, Adam Parr, Joyce Kiel, Dick Swart



State of Wisconsin
2005 - 2006 LEGISLATURE

TODAY

W m is run
LRB-4275/P1
CMH&PJK/ld/jf
"Kay" → stays

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

regenerate

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

1WS
1-5 ✓

that describes

5 SECTION 1. 601.47 (2m) of the statutes is created to read:
6 601.47 (2m) The commissioner shall prepare and publish a ✓ guide to
7 out-of-network coverage for ^{all} defined network plans and distribute it in a manner
8 that the commissioner determines. The cost of publication and distribution may be
9 paid from the appropriation under s. 20.145 (1) (g).

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

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

INS
2-5

5 **SECTION 3.** 609.20 (3) of the statutes is created to read: *L = keep*

6 609.20 (3) The commissioner may not promulgate a rule relating to a preferred
7 provider plan for any of the following purposes:

- 8 (a) To require a specified availability within geographical areas.
- 9 (b) To specify hours of operation, waiting times for appointments in provider
10 offices, or care provided after business hours.
- 11 (c) To require a certain number or certain types of participating providers per
12 enrollees.
- 13 (d) To require any contract between the preferred provider plan and a
14 participating provider to require the participating provider, when scheduling
15 nonemergency care, to disclose to the enrollee the name of any provider participating
16 in the care and to specify whether each provider participating in the care is a
17 participating provider or not.
- 18 (e) To require the services of nonparticipating providers to be covered at the
19 same rate as the services of participating providers if the preferred provider plan
20 fails to comply with certain requirements.

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

22 609.20 (4) The commissioner may promulgate a rule that requires a preferred
23 ~~provider plan to~~ include in its provider directory, in substantially similar language
24 ~~and in at least 11-point bold type,~~ the following notice:

25 **IMPORTANT NOTICE**

Insert 2-22 ✓

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

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

14 **609.21 Rules for limited scope plans.** (1) In this section, “limited scope
15 plan” means a health care plan that provides limited-scope dental or vision benefits
16 under a separate policy, certificate, or contract of insurance.

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

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

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

21 ~~609.22 (4) (a) 2m. The commissioner may not promulgate a rule relating to the
22 use of prior authorization requirements by insurers offering defined network plans
23 that are not preferred provider plans to deny access, or standing referrals, to
24 specialists.~~

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

SECTION 9

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 ⁽¹⁾ 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, ^{the same} but ^{if any} either of the following [✓] applies:

~~1~~ (a) ~~1~~ The coinsurance differential between a participating and a nonparticipating provider for the service is ~~more than~~ 40 percent. ^{paid by an insured} ^{or less} ^{use 2 times}

~~2~~ (b) ~~2~~ Coinsurance for the service when performed by a nonparticipating provider is ~~more than~~ 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 treatment of the emergency medical condition.

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

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

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

11 **SECTION 13. Nonstatutory provisions.**

12 (1) STUDY ON USE OF PRIOR AUTHORIZATION TO DENY ACCESS. The office of the
13 commissioner of insurance shall, through use of its complaint process, conduct a
14 study on whether insurers that offer defined network plans, as defined in section
15 609.01 (1b) of the statutes, that are not preferred provider plans, as defined in section
16 609.01 (4) of the statutes, require prior authorization as part of the procedure for
17 obtaining a standing referral to a specialist under section 609.22 (4) of the statutes
18 and shall determine if requiring prior authorization is used for denying standing
19 referrals to specialists without just cause and with such frequency as to indicate a
20 general business practice. Within one year after the effective date of this subsection,
21 the office of the commissioner of insurance shall submit to the appropriate standing
22 committees of the legislature, in the manner provided under section 13.172 (3) of the
23 statutes, a report of the results of the study that includes documentation in support
24 of any determinations made.

25 **SECTION 14. Initial applicability.**

145
5-25 ✓

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

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

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

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

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

14 (END)

Insert 6-13

2005-2006 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-4275/P2ins
CMH&PJK:jld:jf

*LRS -
inserts
out of order

INSERT 2-5PJK (to ins 2-5)

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

(END OF INSERT 2-5PJK)

INSERT 2-22

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

5 609.20 (4) The commissioner may not promulgate a rule that requires a defined
6 network plan to provide notice about nonparticipating provider limitations in
7 addition to the notice required under s. 609.23 (1).

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

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

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

14 609.23 Required notices. (1) DEFINED NETWORK PLANS. A defined network
15 plan shall include in its marketing materials, in substantially similar language, the
16 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

INS
cmh I
(to ins
2-22)

move to next
line



1 nonparticipating providers. Your plan may actually reduce your benefits
2 when you use nonparticipating providers. To find out about your benefits,
3 please read the benefit information found in these materials and in your
4 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.

5 (2) PREFERRED PROVIDER PLANS. A preferred provider plan shall

(END OF INSERT 2-22)

INSERT 6-13

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

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

(END OF INSERT 6-13)

2005-2006 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-4275/P2insch
CMH&PJK:jld:jf

1 Insert 1-5

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

3 51.20 (7) (am) A subject individual may not be examined, evaluated or treated
4 for a nervous or mental disorder pursuant to a court order under this subsection
5 unless the court first attempts to determine whether the person is an enrollee of a
6 health maintenance organization, limited service health organization or preferred
7 provider plan, as defined in s. ~~609.01~~ 600.03 (37m), and, if so, notifies the
8 organization or plan that the subject individual is in need of examination, evaluation
9 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.

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

11 149.10 (8m) "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~
12 600.03 (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.

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

14 150.84 (5) "Preferred provider plan" has the meaning given in s. ~~609.01 (4)~~
15 600.03 (37m).

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

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

17 600.03 (23g) (a) Contracts with a health maintenance organization, limited
18 service health organization or preferred provider plan, ~~as defined in s. 609.01,~~ to
19 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.

20

as defined in s. 609.01 (2),

1 Insert 2-5

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

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

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

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

12 609.20 (3) Except as provided otherwise in this chapter, the commissioner may
13 not promulgate a rule or impose any requirement that regulates a contract between
14 a preferred provider plan and its participating providers.

Insert 2-5 PJK →

(end ins 2-5)

for the provision of obstetric and gynecologic services

16 Insert cmh1 (to Insert 2-22)

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

18 609.22 (1m) ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. (a) A preferred
19 provider plan meets the requirements listed in sub. (1) if the preferred provider plan
20 ensures that each enrollee has access to at least one primary provider, who may also
21 provide the services of an obstetric and gynecologic provider.

shall ensure → female → care → To satisfy →

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

imposes requirements

(end ins cmh1 to Ins 2-22)

relative to access to obstetric and gynecologic services

1 Insert 5-25

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

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

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

5 632.745 (15) "Insurer" means an insurer that is authorized to do business in
6 this state, in one or more lines of insurance that includes health insurance, and that
7 offers health benefit plans covering individuals in this state or eligible employees of
8 one or more employers in this state. The term includes a health maintenance
9 organization, a preferred provider plan, as defined in s. 609.01 (4), an insurer
10 operating as a cooperative association organized under ss. 185.981 to 185.985 and
11 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.

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

13 632.84 (3) EXCEPTIONS. This section does not apply to a health maintenance
14 organization, limited service health organization or preferred provider plan, as
15 defined in s. 609.01.

*as defined in
s. 609.01 (3)*

as defined in s. 609.01 (2)

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

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

17 632.86 (1) (a) "Disability insurance policy" has the meaning given in s. 632.895
18 (1) (a), except that the term does not include coverage under a health maintenance
19 organization, as defined in s. 609.01 (2), a limited service health organization, as
20 defined in s. 609.01 (3), a preferred provider plan, or a
21 sickness care plan operated by a cooperative association organized under ss. 185.981
22 to 185.985.

History: 1991 a. 70.

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



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 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, 8226 (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.

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

5 635.02 (8) "Small employer insurer" means an insurer that is authorized to do
 6 business in this state, in one or more lines of insurance that includes health
 7 insurance, and that offers group health benefit plans covering eligible employees of
 8 one or more small employers in this state, or that sells 3 or more individual health
 9 benefit plans to a small employer, covering eligible employees of the small employer.
 10 The term includes a health maintenance organization, as defined in s. 609.01 (2), a
 11 preferred provider plan, ~~as defined in s. 609.01 (4)~~,[✓] and an insurer operating as a
 12 cooperative association organized under ss. 185.981 to 185.985, but does not include
 13 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

Don Schwartze

for 609.22 (1m) need access

to primary care providers for 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

LRB-4275/lins
CMH&PJK:jld:rs

INSERT A

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.

promulgating a rule that

or that

insert A-1

fixed by an enrollee

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

nm is run
LRB-4275/P2
CMH&PJK:jld:ta
starts
"Kay"
↓
i/kjt

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

today -
noon

regenerate ↓

1 AN ACT *to repeal* 611.67 (1) (d) and 628.36 (2m) (a) 3.; *to renumber* 609.01 (4),
2 609.35 and 609.82; *to amend* 51.20 (7) (am), 149.10 (8m), 150.84 (5), 600.03
3 (23g) (a), 601.47 (3), 632.745 (15), 632.84 (3), 632.86 (1) (a), 632.895 (14) (d) 3.
4 and 635.02 (8); and *to create* 601.47 (2m), 609.01 (4g), 609.20 (3), 609.20 (4),
5 609.22 (1m), 609.22 (9), 609.23, 609.35 (1) and 609.82 (2) of the statutes;
6 **relating to:** defined network plans → insert 1-6

insert A →

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:

7 SECTION 1. 51.20 (7) (am) of the statutes is amended to read:
8 51.20 (7) (am) A subject individual may not be examined, evaluated or treated
9 for a nervous or mental disorder pursuant to a court order under this subsection
10 unless the court first attempts to determine whether the person is an enrollee of a

SECTION 1

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

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

7 149.10 (8m) “Preferred provider plan” has the meaning given in s. ~~609.01 (4)~~
8 600.03 (37m).

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

10 150.84 (5) “Preferred provider plan” has the meaning given in s. ~~609.01 (4)~~
11 600.03 (37m).

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

13 600.03 (23g) (a) Contracts with a health maintenance organization, as defined
14 in s. 609.01 (2), limited service health organization, as defined in s. 609.01 (3), or
15 preferred provider plan, ~~as defined in s. 609.01~~, to provide health care services.

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

17 601.47 (2m) The commissioner shall prepare and publish a guide that
18 describes out-of-network coverage for all defined network plans and distribute it in
19 a manner that the commissioner determines. The cost of publication and
20 distribution may be paid from the appropriation under s. 20.145 (1) (g).

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

22 601.47 (3) FREE DISTRIBUTION. The commissioner may furnish free copies of the
23 publications prepared under subs. (1) ~~and~~, (2), and (2m) to public officers and
24 libraries in this state and elsewhere. The cost of free distribution shall be charged
25 to the appropriation under s. 20.145 (1) (g).

Insert 3-1

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

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

3 609.01 (4g) Notwithstanding s. 600.03 (37m), "preferred provider plan" means
4 a health benefit plan offered by an organization established under ch. 185, 611, 613,
5 or 614 or issued a certificate of authority under ch. 618 that makes available to its
6 enrollees, without referral and for consideration other than predetermined periodic
7 fixed payments, coverage of either comprehensive health care services or a limited
8 range of health care services, regardless of whether the health care services are
9 performed by participating or nonparticipating providers.

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

11 609.20 (3) (a) Except as provided otherwise in this chapter, the commissioner
12 may not promulgate a rule or impose any requirement that regulates a contract
13 between a preferred provider plan and its participating providers.

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

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

18 609.20 (4) The commissioner may not promulgate a rule that requires a defined
19 network plan to provide notice about nonparticipating provider limitations in
20 addition to the notice required under s. 609.23 (1).

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

22 609.22 (1m) ACCESS STANDARDS FOR PREFERRED PROVIDER PLANS. (a) To satisfy
23 the requirements in sub. (1), a preferred provider plan shall ensure that, for the
24 provision of obstetric and gynecologic services, each female enrollee has access to at
25 least one primary care provider who provides those services.

Insert 3-22

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

primary care providers or

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

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

5 609.22 (9) PROHIBITION ON USE OF UTILIZATION MANAGEMENT. An insurer offering
6 a preferred provider plan may not use utilization management techniques, including
7 prior authorization requirements or similar methods, to deny access to
8 nonparticipating providers.

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

10 609.23 Required notices. (1) DEFINED NETWORK PLANS. A defined network
11 plan shall include in its marketing materials, in substantially similar language, the
12 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**

13 Please be aware that your benefits when you use participating
14 providers may be different from the benefits when you use
15 nonparticipating providers. Your plan may actually reduce your benefits
16 when you use nonparticipating providers. To find out about your benefits,
17 please read the benefit information found in these materials and in your
18 plan documents, or you may call [insert phone number of insurer].
19
20
21

***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.

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

3 **IMPORTANT NOTICE**

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

16 **SECTION 14.** 609.35 of the[✓] statutes is renumbered 609.35 (2).

17 **SECTION 15.** 609.35 (1) of the[✓] statutes is created to read:

18 **609.35 (1)** In this section, a preferred provider plan covers the same service
19 when performed by a nonparticipating provider that it covers when performed by a
20 participating provider, if any of the following applies:

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

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

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

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

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

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

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

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

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

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

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

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

23 632.745 (15) "Insurer" means an insurer that is authorized to do business in
24 this state, in one or more lines of insurance that includes health insurance, and that
25 offers health benefit plans covering individuals in this state or eligible employees of

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

5 **SECTION 21.** 632.84 (3) [✓] of the statutes is amended to read:

6 632.84 (3) EXCEPTIONS. This section does not apply to a health maintenance
7 organization, as defined in s. 609.01 (2), limited service health organization, as
8 defined in s. 609.01 (3), or preferred provider plan, ~~as defined in s. 609.01~~.

9 **SECTION 22.** 632.86 (1) (a) [✓] of the statutes is amended to read:

10 632.86 (1) (a) “Disability insurance policy” has the meaning given in s. 632.895
11 (1) (a), except that the term does not include coverage under a health maintenance
12 organization, as defined in s. 609.01 (2), a limited service health organization, as
13 defined in s. 609.01 (3), a preferred provider plan, ~~as defined in s. 609.01 (4)~~, or a
14 sickness care plan operated by a cooperative association organized under ss. 185.981
15 to 185.985.

16 **SECTION 23.** 632.895 (14) (d) 3. [✓] of the statutes is amended to read:

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

20 **SECTION 24.** 635.02 (8) [✓] of the statutes is amended to read:

21 635.02 (8) “Small employer insurer” means an insurer that is authorized to do
22 business in this state, in one or more lines of insurance that includes health
23 insurance, and that offers group health benefit plans covering eligible employees of
24 one or more small employers in this state, or that sells 3 or more individual health
25 benefit plans to a small employer, covering eligible employees of the small employer.

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

5 **SECTION 25. Initial applicability.**

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

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

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

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

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

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

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

8

(END)

2005-2006 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-4275/lins
PJK:.....

INSERT 1-6

relating clause ↓
no #

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)

**2005-2006 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU**

LRB-4275/lins
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INSERT A

1002

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.

X 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/lins
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(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.

does all of the following: #

~~# 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)

move

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