Joint Committee for Review of Administrative Rules
Office of Sen. Glenn Grothman
Office of Rep. Mark Gottlieb
Phone: 608.266.7513
Phone: 608.267.2369

- **INS 9**

Report to the Legislature
INS 9

The Joint Committee for Administrative Rules

Produced pursuant to 227.19(6)(a), Stats.

INS 9, promulgated by the Office of the Commissioner of Insurance (OCI), regulates Defined Network Plans, specifically establishing financial standards for Health Maintenance Organizations (HMOs) or Limited Service Health Organizations (LSHOs) and establishing market conduct standards for defined network plans.

Description of the Problem

2001 Wisconsin Act 16 eliminated the use of the term "managed care plan" and substituted the term "defined network plan" and made various changes to Chapter 609, WI Stats., which now relates to defined network plans. After the passage of 2001 Act 16, the OCI submitted Clearinghouse Rule 02-69 (CR 02-69), proposing amendments to chapter INS 9, WI Adm. Code, to refer to defined network plans, rather than managed care plans, and to implement the other changes made by Act 16. The chairs of both committees to which CR 02-69 was referred (the Assembly Committee on Health and the Senate Committee on Insurance, Tourism, and Transportation) requested a meeting with OCI. OCI then submitted several modifications to CR 02-69. Eventually, OCI withdrew CR 02-69 without promulgating it. In 2004, OCI attempted to proceed with CR 02-69, but discontinued that effort after the Legislative Council Clearinghouse indicated that there was no statutory process for resubmitting a withdrawn rule to the Legislature.

OCI has now submitted Clearinghouse Rule 05-59 (CR 05-59) to change references in the Administrative Code from managed care plan to defined network plan and to implement the changes made by Act 16. Following submission of CR 05-59 to the Legislature, the rule was referred to the Assembly Committee on Insurance and the Senate Committee on Agriculture and Insurance. The committees held a joint public hearing, after which they requested modifications to the rule. The agency made some modifications to the rule. The Senate committee requested additional modifications, and objected to the rule when OCI refused to make the modifications.

Arguments in Favor of Suspension

- Preferred Provider Plans (PPPs) and hospitals are not currently able to provide every patient with the name of every health care provider that might participate in a non-elective or non-emergency procedure (including surgery), along with information about whether that health care provider is a participating provider in that patient's PPP.
- Limited scope plans, such as dental and vision plans, were never intended to be regulated as "defined network plans" and should not be a part of this rule.
- Under the rule, PPPs would be required to treat emergency care as in-network, even if the service performed was out-of-network. Emergency medical service should mean health care services necessary to screen and stabilize a person in connection with a medical emergency. Patients could be transferred to a network provider for admission once they are stabilized and able to be transferred without deterioration of the medical condition.
- With respect to pre-authorization, the standards of "without just cause" and "with such frequency as to indicate a general business practice" are unclear.
- The access standards are unworkable, and would force PPPs to control doctor office operations, including hours of operation.
- A review of complaints submitted to OCI showed that there were not a large number of complaints that would be resolved under the changes in CR 05-59.

Arguments Against Objection

- Patients can only help control health care costs if they know whether the health care provider is in or out of network. Patients should never, unknowingly, become responsible for large medical bills for service from out-of-network providers that the patient believed was being provided by network providers.
- Limited scope plans should be regulated.
- Defined network plans and PPPs that provide emergency room care as a covered benefit should provide coverage as though the provider was a participating provider when the enrollee cannot reasonable reach a preferred provider or is admitted for in-patient care by a non-participating provider..
- Those PPPs that restrict patients' choices by denying pre-authorization requests and, thus, operate like Health Maintenance Organizations (HMOs), should be regulated like HMOs.
- PPPs should be required to have a sufficient number and type of provides to adequately deliver all covered services. Enrollees should be able to obtain services within a reasonable distance and within a reasonable amount of time.

Action by Joint Committee for Administrative Rules

On December 14, 2005, the Joint Committee for Review of Administrative Rules held a public hearing on CR 05-059. On December 22, 2005, the committee requested modifications, which the department declined to make. The committee took no further action on Clearinghouse Rule 05-059, which was then published by the Revisor in the Wisconsin Administrative Register, with an effective date of March 1, 2006.

On March 1, 2006, the Joint Committee for Review of Administrative Rules held a public hearing and executive session on INS 9. JCRAR passed the following motions to suspend portions of INS 9:

> 1. By a vote of 8-1, with 1 absent, the Joint Committee for Review of Administrative Rules, pursuant to ss. 227.19 (4) (d) 1., 3., and 6. and 227.26 (2) (d), Stats., suspends all of the following, on the basis of an absence of statutory authority, a failure to comply with legislative intent, and that it is arbitrary, capricious, or imposes an undue hardship:
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> a. Section Ins 9.01 (10m).

b. The phrase "or limited scope plan" in ss. Ins 9.01(9m), and 9.20 (intro.) (second occurrence), and 9.42 (1) (second occurrence).

c. The phrase "or limited scope" in ss. Ins. 9.01(5) and (13), 9.07, 9.20 (intro.) (first and second occurrences), 9.41, and 9.42(1) (first occurrence) and (5)(a).

2. By a vote of 6-4, the Joint Committee for Review of Administrative Rules, pursuant to ss. 227.19 (4) (d) 6. and 227.26 (2) (d), Stats., suspends s. Ins 9.25 (4) on the basis that it is arbitrary and capricious, or imposes an undue hardship.

3. By a vote of 6-4, the Joint Committee for Review of Administrative Rules, pursuant to ss. 227.19 (4) (d) 6. and 227.26 (2) (d), Stats., suspends part of s. Ins 9.32 (2) (a) as follows on the basis that it is arbitrary and capricious, or imposes an undue hardship:

> Ins 9.32 (2) (a) Provide covered benefits by participating providers with reasonable promptness with respect to geographic location~~, hours of operation, waiting times for appointments in provider offices and after hours care. The hours of operation, waiting times, and availability of after hours care shall reflect the usual practice in the local area~~. Geographic availability shall reflect the usual medical travel times within the community. This does not require an insurer offering a preferred provider plan to offer geographic availability of a choice of participating providers.

4. By a vote of 10-0, the Joint Committee for Review of Administrative Rules, pursuant to ss. 227.19 (4) (d) 6. and 227.26 (2) (d), Stats., suspends s. Ins 9.32 (2) (c) and (e) 1. and the phrase "(c) and" in s. Ins 9.33 on the basis that it is arbitrary and capricious, or imposes an undue hardship.

5. By a vote of 6-4, the Joint Committee for Review of Administrative Rules, pursuant to ss. 227.19 (4) (d) 6. and 227.26 (2) (d), Stats., suspends s. Ins 9.32 (2) (f) on the basis that it is arbitrary and capricious, or imposes an undue hardship.

This action prevents the OCI from enforcing these portions of INS 9.

On March 29, 2006, the JCRAR held an executive session and voted, 6-3 with one member absent, to introduce LRB 4803/1 and 4802/2, which makes the effect of the suspension statutory.