WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Agriculture and Insurance (SC-AI)

Sample:

Record of Comm. Proceedings ... RCP
- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Appointments* ... *Appt*
- **

- *Clearinghouse Rules* ... *CRule*
- **05hr_CRule_05-059_SC-AI_pt01**

- *Committee Hearings* ... *CH*
- **

- *Committee Reports* ... *CR*
- **

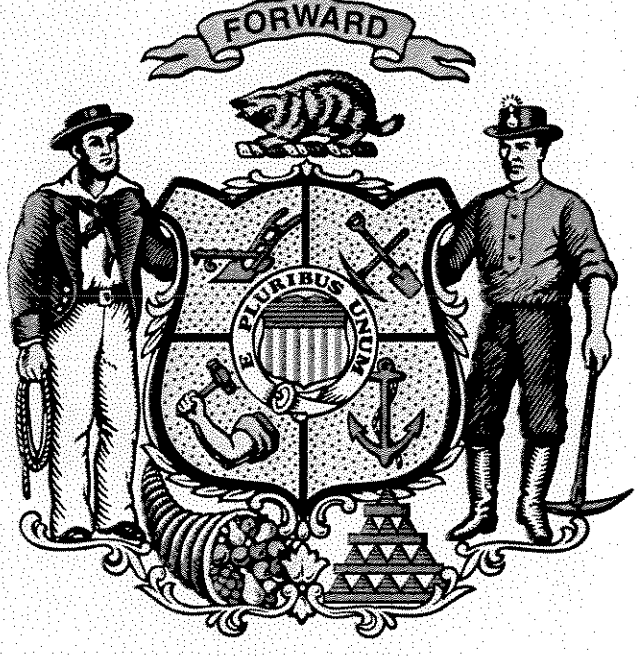
- *Executive Sessions* ... *ES*
- **

- *Hearing Records* ... *HR*
- **

- *Miscellaneous* ... *Misc*
- **

- *Record of Comm. Proceedings* ... *RCP*
- **

- Joint Public Hearing - Oct 13, 2005 -


FORWARD
E PLURIBUS UNUM

JSOnline MILWAUKEE JOURNAL SENTINEL www.jsonline.com Return to regular view

Original URL: http://www.jsonline.com/bym/news/aug05/349753.asp

The doctor is not in — your plan

Patients pay more when PPOs omit hospital physicians

By GUY BOULTON
gboulton@journalsentinel.com

Posted: Aug. 20, 2005

Lisa Schmidt learned about one of the quirks of health insurance when she went to Oconomowoc Memorial Hospital with severe abdominal pain.

She knew the hospital was part of her health plan's network. She didn't know that the doctors who staff the hospital's emergency department were not.

"Nobody even tells you that is a possibility until you get the bill in front of you," Schmidt said. "And then you are trying to figure out what happened."

At the time, Lake Country Emergency Physicians, which staffs the hospital's emergency department, did not have a contract with her family's health plan, Blue Cross Blue Shield of Wisconsin.

As a result, Schmidt had to pay a larger share of the bill for seeing a doctor who wasn't part of the health plan's network.

It's one of the potential pitfalls of preferred provider organizations, the most popular type of health plan.

A PPO is a network of doctors and hospitals that has given discounts to a managed care company in exchange for being given preferred access to the potential patients in a health plan.

The catch is that a hospital may be part of a health plan's network, but the radiologists, anesthesiologists, pathologists and emergency physicians who work at the hospital may not be.

There's no practical way, though, for people to know that.

"I could not have interviewed every person who was going to take care of me and ask, 'Are you part of my network?' " said Schmidt, who lives near Pewaukee. "As a patient, there are only so many things you can do. That is what is so frustrating."

The problem - while not widespread - has generated enough complaints to prompt the state insurance commissioner to propose a rule that effectively would require hospitals to warn patients for elective care when a doctor is not part of their health plan's network.

It also has prompted some managed care companies to take steps designed to put pressure on hospital-based physicians to sign contracts with them - steps that one consultant likens to "blackmail."

The problem suggests that for all the talk of people becoming more involved in their health care decisions - what is called consumerism" - the intricacies of the health care system have a way of surprising people.

"It seems there's a different set of rules for every little thing," Schmidt said.

After all, how many people would think to ask whether the radiologist who reads an X-ray or the anesthesiologist in the operating room is part of their health plan's network?

Even if they did ask, there's not much they could do about it. That's because hospitals typically give exclusive contracts to the physician groups that staff their emergency, radiology and pathology departments. The doctors basically have a monopoly - and patients don't get to shop around when hospitalized.

Doctors vs. providers

The problem is an outgrowth of the ever-present tension between doctors and managed care companies over fees.

The managed care companies blame the doctors, contending that their monopoly gives them little incentive to negotiate on price.

Doctors, on the other hand, complain that managed care companies know that hospitals will pressure the physicians to sign contracts.

"You sometimes are expected to take the contract, and they know it," said Robert Chang, owner of Health Care Management Consulting, an Elm Grove firm that advises doctors in small and midsize groups on business and practice management.

For their part, health care systems "encourage" - but don't require - their hospital-based physicians to sign contracts with health plans that contract with the hospital.

"We understand the problem and don't want to see patients in the middle," said Anne Ballentine, a spokeswoman for Covenant Healthcare. "There are instances of it in our system. It's not widespread."

Other health care systems take the same position.

"Aurora has largely been able to avoid the problem," said Jeff Squire, a spokesman for Aurora Health Care. "But we agree it can be a significant problem for patients."

Some of those patients have made their frustrations known to state regulators.

'This was a frequent complaint," said Eileen Mallow, a spokeswoman for the Office of the Commissioner of Insurance.

Disclosure urged

The pending rule would require health plans to include language in their contracts with hospitals and physicians that requires them to tell patients if an out-of-network doctor will be involved in their care. It is part of a broader rule regarding the regulation of preferred provider organizations.

The state insurance commissioner expects to submit the proposed rule to the Legislature early next month. The Legislature then can recommend changes or hold a hearing on the proposed rule. If approved by the Legislature, the rule would go into effect Jan. 1, 2007.

It would not affect health plans of employers who self-insure. Those plans are regulated by the federal government.

Some managed care companies welcome the proposed rule.

"It is going to give consumers more information than they have now," said Karen Geiger, a lawyer with Blue Cross.

The managed care companies, which put together preferred provider organizations and oversee health plans, have taken their own steps to deal with the problem.

Proactive changes

Beginning around April, UnitedHealthcare changed the way it pays hospital-based doctors, such as radiologists and emergency physicians, who won't sign contracts.

The company used to pay its share of the bill by directly reimbursing the doctor. Now, in some cases, it sends a check to the patient.

As might be expected, some of those patients cash the check but don't pay the doctor.

The move is designed to remind doctors of the advantage of belonging to a health plan's network.

"That's exactly what we are hoping will happen," said Jay Fulkerson, president and chief executive of UnitedHealthcare of Wisconsin.

UnitedHealthcare isn't alone in trying to pressure hospital-based doctors to sign contracts. For several years, Blue Cross hasn't sent checks to doctors who don't sign contracts.

"Being paid directly by an insurer is one of the incentives of joining a network," said Jill Becher, a spokeswoman for Blue Cross.

Some physician groups aren't happy about the practice.

"What they are trying to do is blackmail the providers," said Donald Stewart, a partner in Healthcare Management Consultants, a Menasha firm that advises medical groups. "They are holding a club over the doctor's head."

Doctors still paid well

For hospital-based physicians, belonging to a preferred provider organization doesn't bring them additional patients, since they already treat all of the hospital's patients who need their services.

At the same time, doctors who work out of hospitals must treat everyone admitted to the hospital. For this reason, they see more uninsured patients and provide more charitable and uncompensated care than their counterparts who are based in clinics.

They also see a larger share of Medicare and Medicaid patients. The two programs, particularly Medicaid, pay less than private health plans.

A doctor who works in a clinic, in contrast, can choose not to see people without health insurance or who are enrolled in the Medicaid program.

That said, hospital-based physicians typically earn a nice living.

Compensation for radiologists, for instance, ranges from $201,699 to $412,217 a year, according to a review of surveys on physician compensation compiled by Merritt, Hawkins & Associates, a recruiting firm.

For anesthesiologists, it ranges from $258,277 to $341,407 a year. And for emergency physicians, it ranges from

$167,621 to $236,000.

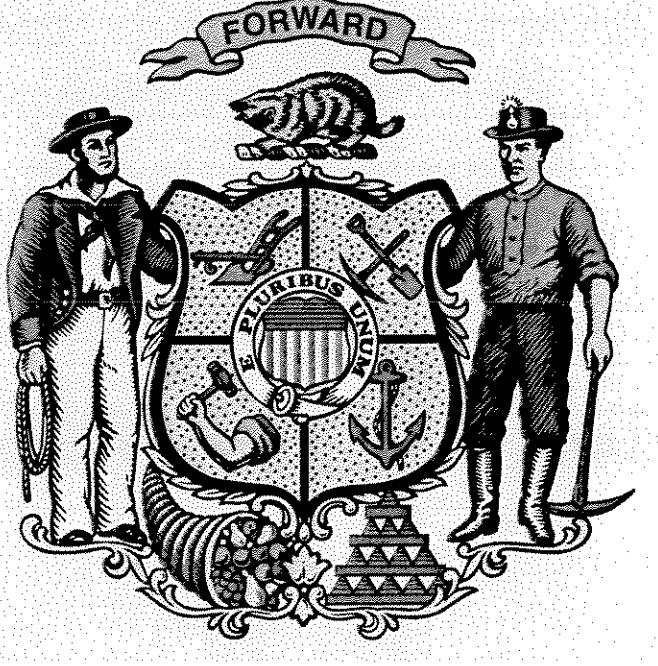
Some doctors believe they should contract with all the health plans that contract with the hospitals where they work.

"If I am treating a patient for cancer, the last thing they need to worry about is their insurance," said Mitchell Pincus, a radiation oncologist at Aurora St. Luke's Medical Center and Aurora Sinai Medical Center.

That can mean accepting whatever contract is offered by the managed care company.

"You try to negotiate for the best rate you can, but they also know they got you, and there's not a lot of negotiating," Pincus said.

From the Aug. 21, 2005, editions of the Milwaukee Journal Sentinel


FORWARD
E PLURIBUS UNUM

October 10, 2005

Golden Rule Insurance Company
Concerns with Wisconsin Clearinghouse Rule 05-059
(Wisconsin Insurance Regulation Chapter 9)

- Some of the proposed changes to Wisconsin Insurance Regulation Chapter 9 (INS 9) create regulatory policy that exceeds statutory language.

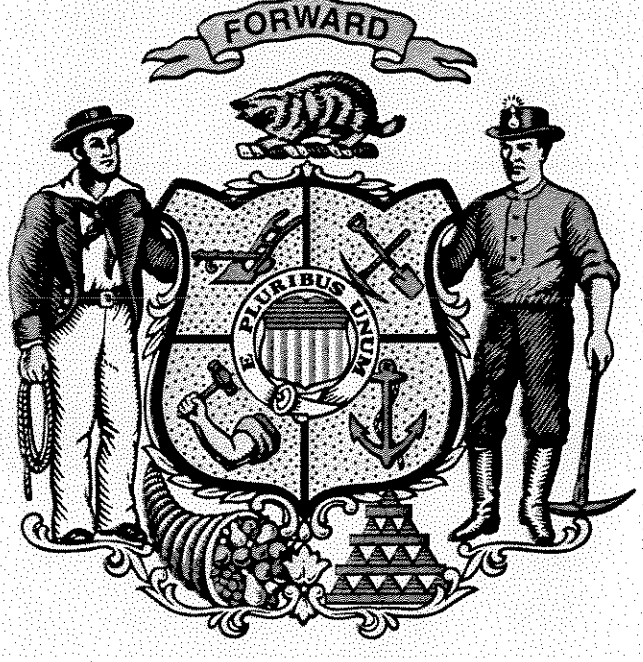
- These changes create regulations that were never intended by the legislature in 2001 Wisconsin Act 16.

- Some specific regulations contained in the rule will restrict the types of health insurance policies available to consumers in Wisconsin.

- It requires a retroactive compliance on all current policy forms previously filed and approved by OCI.

- Wisconsin policy owners will be affected as insurance carriers try to bring all policies into compliance with this regulatory framework.

Josh Watson
Government Relations
Golden Rule Insurance Company


FORWARD
E PLURIBUS UNUM

WAPN
WISCONSIN ASSOCIATION
OF PROVIDER NETWORKS

4600 American Parkway • EastPark One • Ste. 208 • Madison, WI 53718
(608) 243-1007 • Fax (608) 241-7790

Joint Hearing of the Senate & Assembly Insurance Committees October 13, 2005

Written Testimony for Clearinghouse Rule 05-059

Thank you for the opportunity to provide written testimony on Clearinghouse Rule 05-059. The Wisconsin Association of Provider Networks (WAPN) is Wisconsin's PPO association. WAPN members represent nearly 1.8 million Wisconsin consumers, and in 2004, our combined membership reprocessed over $4 Billion dollars of health care charges, providing millions of dollars of savings to consumers.

The Preferred Provider Organization (PPO) plan design is the most widely purchased plan, not only in Wisconsin but nationally. According to a *Kaiser Employer Health Benefits 2005 Annual Survey*, PPO Plans have the highest enrollment covering 61% of covered workers, up from 55% in 2004. The plan with the next highest enrollment fell to 21% of total covered workers from 25% last year. The Midwest data in this same survey shows even a higher penetration by PPO's at 70%. *[See attached exhibits].* PPO's have not only provided consumers with the ability to negotiate competitive health care rates, but have given consumers the complete freedom of provider choice. As a result, PPO's have received the highest satisfaction rate of any type of plan, according to a *Deloitte & Touche 2003 Employer Health Care Survey*. With so many consumers not only covered by a PPO plan, but satisfied with them, it is imperative that any statute or regulation preserve the viability of this market. To that end, we respectfully address our concerns with CR05059 and the negative effect it will have on PPO plans in Wisconsin.

To start, the sole purpose in revising Ins 9 was based upon the statutory changes made by the legislature in 2001 Wisconsin Act 16. Specifically, changes were made to Chapter 609 in an effort to properly recognize the differences that exist between HMO and PPO plan designs. These changes were necessary in order to ensure the continued viability of PPO's in Wisconsin, as some of the provisions in Chapter 609 were impossible for PPO's to comply with. It was therefore our anticipation that the OCI would draft a revision to Ins 9 based upon the wishes of the legislature and the intent behind the revised statute. Unfortunately, throughout the last four years of discussion, and as evidenced in this latest Clearinghouse Rule, it appears the department is reaching beyond their statutory authority, and more importantly, disregarding the legislative intent.

In their "*plain language analysis and summary of the proposed rule*", the OCI states that consumer complaints are the rationale for making these proposed changes. However, we feel their argument is irrelevant without the full disclosure and review of these complaints by either the industry or the legislature. The Wisconsin Association of Provider Networks has requested more detailed information regarding these alleged complaints on numerous occasions. However, to date, our request has been unanswered, including our request for review of these complaints under open records laws. The only information we have received is a "summary" of the complaints completed by the OCI. While we are appreciative of the summary and the effort in producing it, unfortunately, it does not provide the detailed information needed to make a rational decision as to what the extent of any specific problem within the market might be. Furthermore, it does not allow the opportunity to analyze whether the department properly categorized the complaints between HMO and PPO business. How are we assured that the complaints they list as "PPO Complaints" are not actually complaints regarding a PPO plan marketed by an HMO insurer? In addition, the summary does not explain the resolution of these complaints. Many of these complaints may have, in fact, proven to be a lack of understanding by the insured and perhaps there was no wrong doing by the insurer at all. Furthermore, the summary identifies a total of 936 complaints over nearly a year and a half. However, when they attempt to categorize these complaints into 6 areas, they only identify 314 complaints. What is the other alleged 622 complaints relating to?

We are grateful for the time the OCI has committed to this regulation, and the improved effort this department has made towards meeting with the industry. However, we believe the department should revise Ins 9 based only on the intent of the statutory changes made to Chapter 609, or provide more detailed complaint information regarding their concerns about PPO's so that legislators can make an informed and intelligent decision if further statutes and regulations are necessary in order to protect Wisconsin consumers.

The following are our specific comments and concerns [Please note that PPO's are referred throughout the regulation as Preferred Provider Plans (PPP's):

1. The inclusion of limited scope plans. Under Ins 9.01 (10m), the regulation is attempting to include limited scope plans, like dental and vision plans, into specific provisions of the regulation.

Summary – This broad inclusion is not consistent with either federal laws like HIPAA, or even our state laws. The inclusion of these limited benefit plans was simply not contemplated in the development of Chapter 609, nor in the changes that occurred with 2001 Wisconsin Act 16. This provision was not even contemplated by the OCI in their first draft of revising Ins 9 (Please see Clearinghouse Rule 02-069) In fact, this inclusion of dental and vision plans was not even proposed by OCI until sometime in late 2004 or early 2005.

Recommendation – This provision should be deleted in its entirety.

2. Preferred provider plan same service requirements – Under Ins 9.25, there are certain requirements that the regulation places on PPP's in order to qualify for the exemptions that Chapter 609.35 provides. Please note that 609.35 provides the exemptions that the legislature granted in order to properly differentiate between HMO's and PPP's. The following are the specific concerns with Ins 9.25:

2a. **The expectation of "substantial coinsurance coverage".** In Ins 9.25 (1), the proposed rule states that in order to satisfy 609. 35, PPP's must have a minimum coinsurance rate for out of network coinsurance payments. The co-insurance is the percentage of a claim that is paid by the insurer once the deductible is satisfied. The regulation requires a minimum coinsurance rate of 60% for out-of-network providers – meaning that the coinsurance rate for in-network providers is usually higher than 60%. A plan can have a co-insurance rate of 50% for out-of-network providers if a disclaimer is printed prominently and provided at the time of solicitation. The regulation does not define how this disclaimer should be provided (i.e.: brochures, provider directory, additional disclosure piece, etc).

For reference, s. 609.35 simply states:

609.35 Applicability of requirements to preferred provider plans. Notwithstanding ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to the requirements under ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1).
History: 2001 a. 16.

Summary – This section not only exceeds the department's statutory authority, but will continue to make health care, and ultimately health insurance, unaffordable for consumers. There is strong a desire to solve our health care cost crisis by free market solution rather than increased government intervention. The incentives used by PPP's to seek cost effective health care are essential to providing a free market solution. Equally important, the purpose of s. 609.35 and the issue of ensuring that the same "services" are available for both in network and out of network providers had nothing to do with what level or what coverage these services would be provided. The issue was to assure the PPP's provided for the same services (such as transplants or routine care) in network as they did for out of network providers. Therefore, we believe, that the OCI is going outside of the legislative intent relative to the 609.35.

Additionally, it appears that the Wisconsin Legislative Council agrees with our viewpoint. In their comments relative to OCI's first draft of the revisions to Ins 9, found in Clearinghouse Rule #02-069, and in particular to this provision in the rule, Legislative Council states that "*While s. 609.35, Stats., refers to "covering" the same services, it does not require that the level of benefits for the covered services be the same regardless of whether the service is by a participating provider or nonparticipating provider. For example, the statute does not specify that there cannot be a different deductible or coinsurance provision if the service is performed by a nonparticipating provider rather than a participating provider or that the reimbursement rates to the providers must be the same.*" They further state, "*It does not appear that there is statutory authority for these provisions.*"

What is also curious about this provision is that it is not equally applied to all defined network plans. An HMO Point of Service plan could, in fact, have a coinsurance rate that is lower than a PPO's minimum rate of 60% and not be required to provide the consumer with the same disclosure statement. If the OCI is attempting to protect consumers against out-of-network coverage limitations, why is this disclaimer selectively applicable to only PPP's?

Recommendation – While there is no authority provided to the OCI through the statutes for this provision, and while there is no legislative intent for this provision, WAPN does recognize that co-insurance levels that are so extreme as to essentially not provide "coverage" for services out-of-

network cannot claim to have out-of-network coverage. It is for this reason we agreed to negotiate acceptable language in December of 2002 with the legislature and the department. Ultimately, that agreement was withdrawn by the department. That compromise consisted of a minimum coinsurance rate of 50%, but did not include the pejorative language found in Ins 9.25 (5). We would recommend that Ins 9.25 (1) require a minimum coinsurance rate of 50% and that Ins 9.25 (5) be deleted in its entirety. Additionally, if the department feels the need to notify consumers about all plans that provide reduced out-of-network coverage, they should produce a consumer guide to Defined Network plans that discusses all types of plans and their out-of-network coverage.

2b. **The pre-authorization provision".** In Ins 9.25 (4), the proposed rule includes the caveat that to be a PPP, an insurer must not use utilization management tools, such as pre-authorization, to deny access to non-participating provider without just cause and with such frequency as to indicate a general business practice. If determined by the department that these utilization management tools are used without just cause, it would remove your PPP status according to Chapter 609.35.

Summary – At issue is how the OCI would view "without just cause" and "with such frequency as to indicate a general business practice". As the language stands now, it is completely at the discretion of the department. This provision exceeds the department's statutory authority. This same provision was also found in Clearinghouse Rule #02-069. In comments made by the Wisconsin Legislative Council Rules Clearinghouse relative to this provision, Legislative Council stated: "*...the statutes do not require that a preferred provider plan cover the same services both in-plan and out-of-plan without material disincentives in order to be defined as a preferred provider plan".*

Additionally, WAPN provided the OCI with 2004 statistics that compared over 5,000 pre-authorizations. The data looked at how many days of hospitalization were denied to in-network providers as compared to out-of-network providers. This data showed that there was less than 2% variance between these denials. WAPN asked the department to review this data and/or to produce other data that conflicted with our findings. To date, WAPN has not received any response to our inquiry.

Recommendation – Unless the department can show data contrary to that which was produced by WAPN, we recommend that Ins 9.25 (4) be deleted in its entirety.

3. The expectation of additional "substantial coverage" provisions. Under Ins 9.27, the OCI places additional restrictions on PPP's. These additional restrictions are similar to the substantial coinsurance coverage listed in 2b above. Under 9.27, a PPP must have no greater than a 30% coinsurance differential. This means that the coinsurance for in-network must not be greater than 30% of the out-of-network coinsurance rate. (90% in-network and 60% out-of-network). In addition, this provision also requires the deductible for out-of-network providers be no higher than 2 times the in-network deductible (or no greater than $2,000). Additionally, the provision attempts to regulate co-payments in the same manner as deductibles and coinsurance differentials. These provisions, like the coinsurance minimum provision found in Ins 9.25 (1), also provides the ability for insurers to exceed these deductible and co-payment limits if the same pejorative language found in Ins 9.25 (5) is displayed in marketing materials.

Summary – As stated in 2a. above, the OCI does not have the statutory authority to include these provisions on PPP's. Neither the legislature contemplated these provisions, nor do they meet the legislative intent in the definition of PPP's found in Chapter 609.01 (4). In addition, it is important to note that such purchase decisions should be left up to the consumers that buy these plans, not to a government regulatory agency. In the *Deloitte & Touche 2003 Employer Health Care Survey,* as much as 44% of employers surveyed looked at plan design as their primary strategy in attempting to control the increases in health care costs and insurance premiums. This same survey found 19% thought encouraging employee consumerism was their primary strategy. This provision would not only limit an employer's ability to plan design, but is in direct conflict with the encouragement of employee consumerism. It is vital to employers that affordable coverage options be preserved. Otherwise, the only other alternative might be to simply stop offering employer based coverage.

Recommendation – Also, as stated in 2a. above, while we do not believe there is authority for this provision, we do recognize that some minimums may be in order. If the legislature felt it was appropriate to dictate such minimums within this regulation, rather than by statute, we would agree to adhere to the same minimum we negotiated in our December 2002 agreement. This minimum coverage includes a 40% coinsurance differential. Our 2002 agreement commented on minimum deductibles, but did not commit to any minimum differential. Since December of 2002, with the advent of HSA's and other consumer driven health care plans, we would be concerned about any limitation on deductibles that would be in conflict with HSA laws. Therefore, we would recommend that no language be included that would limit the deductible differential. Finally, we would also recommend that the co-payment differential be deleted in its entirety. It was rather confusing as to why this provision was included in the first place, as most plans do not require co-payments on out-of-network providers; rather they only require co-payments on in-network providers.

4. The inclusion of PPP's in Access Standards. In Ins 9.32 (2)(a) and Ins 9.32 (2)(b), the proposed rule requires PPP's to have control over their contracted providers' business operations. This requirement states PPP's shall *"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".* While the language states it shall "reflect" the usual practice in that location, if a PPP's contracted provider does not "reflect" the norm, than the PPP would no longer be in compliance with this provision. Therefore, in order to be in compliance, a PPP would have to acquire contractual control over a providers' business operation.

For reference, the legislature removed PPP's from s. 609.22 (2), 609.22 (3), 609.22 (4) and 609.22 (7). The removal of PPP's by the legislature from 609.22 (2) specifically provided relief to PPP's from the types of provisions found in Ins 9.32 (2)(a). Specifically, s.609.22 (2) states:

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

The one provision within the access standards of Chapter 609.22 that PPP's were to remain in was s.609.22 (1). This provision intentionally included PPP's as it only required that the plan include a sufficient number and types of qualified providers. It did not require that these qualified providers be participating providers. Specifically, s.609.22 (1) states:

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

Additionally, the legislature created s. 609.20 (2m) to ensure that any regulation must properly recognize the differences between HMO's and PPP's. Specifically, s. 609.20(2m) states:
609.20 Rules for preferred provider and defined network plans. (2m) Any rule promulgated under this chapter shall recognize the differences between preferred provider plans and other types of defined network plans, take into account the fact that preferred provider plans provide coverage for the services of nonparticipating providers, and be appropriate to the type of plan to which the rule applies.

Summary – The continued inclusion of PPP's in these provisions appears to circumvent the legislature's desire to have PPP's removed from the Access Standards. While there are many provisions of the Access Standards that legislator's wanted PPP's to comply with, it was clear the legislature thought PPP's should not be required to follow standards that would require PPP's to have control over their providers operations. This is why 609.22 (1) included PPP's and 609.22 (2) did not, as it understood that access for PPP's included any provider since PPP's were required to provide out-of-network coverage. With no requirement for a referral and coverage for out-of-network providers, PPP's could comply with subsection (1) as it only required access to "qualified" providers, rather than "participating providers" which is included in subsection (2). To further clarify this intent, the legislature also created s.609.20 (2m). This provision was specifically written to prevent the inclusion of PPP's into inappropriate regulatory provisions.

In the OCI's *plain language analysis*, they state that "*This requirement is not new and does not require insurers to mandate to providers the providers hours of operation*". They further go on to state insurers just need to prove those hours are normal for the location. We agree that the regulatory requirement isn't new. It was in the original Chapter 609, but it was thrown out by the legislature with 2001 Wisconsin Act 16. The department is simply trying to reapply it through the rule making process. Additionally, the language in Ins 9.32 (2)(a) does, in fact, mandate insurers have control over the providers operation. The rule states that insurers must comply with the access standards and provides for a penalty for such non-compliance. Additionally, if an insurer is unable to "prove the hours are normal", is it not logical to assume they will find the insurer out of compliance with this provision?

While the OCI wishes for us to trust them relative to how they will apply this provision, our concern is long term. If the provision is written into the regulation, they can subjectively apply it as they wish in the future. What is even more troubling are prior written opinions from the OCI contradicting their own assertions. In a letter written by OCI General Counsel Fred Nepple on December 16, 1999 regarding this very subject, Mr. Nepple states: "*The Office anticipates an insurer will demonstrate compliance with this requirement by maintaining records showing its direct or indirect contractual arrangements with an adequate network of providers, that its contracts include provisions addressing the access issues discussed above, and that it is monitoring and enforcing the contractual provisions.*" In another letter issued by Assistant Deputy Commissioner Eileen Mallow on June 8, 2000, the OCI responds to a request for an opinion as to existing PPO provider contract language that discusses "normal practices and procedures". This is the only language that exists in PPP contracts and WAPN asked if it would satisfy the requirement of the access standards provision. Ms. Mallow replied, "*....the language you submitted does not require providers to adhere to usual practices in the local area with respect to*

waiting and travel times. Additionally, consistent with [Ins 9.42, which is now Ins 9.32 (2) in CR05059], *we would expect that an insurer would also have a procedure or mechanism to monitor provider compliance with the rule requirements.*" Clearly, in both official responses by the department (copies attached), they would require that we have "contractual" authority of the providers' business operations.

This requirement of contractual authority is neither something PPP's can obtain from providers, nor is it the desire of consumers that PPP's have this authority. It also ignores the statutory intent of 2001 Wisconsin Act 16.

Recommendation – These provisions should be deleted in its entirety.

5. The inclusion of PPP's in new provisions of Access Standards. In Ins 9.32 (2)(c), Ins 9.32 (2)(e) and Ins 9.32 (2)(f), the OCI has included an additional requirement for PPP's under the label of Access Standards. These additional provisions require a PPP to force their participating providers to sign an amendment that would require the participating provider to notify their patients prior to a non-emergent visit of all subcontracted services that provider has implemented, and which networks those subcontracted providers participate in. If the PPP fails to get the provider to sign the amendment, and/or if the participating provider fails to give their patients this disclosure of subcontracted services, and if the subcontracted service is provided to the patient and that service is outside the network, the PPP must pay the claim as if it occurred in-network. In other words, they must pay the higher benefit level to the consumer, without the benefit of a discount by the provider.

Summary – To have the legislature require that providers give disclosure on subcontracted services to their patients is something WAPN could support. However, for the OCI to require insurers to require providers to give this disclosure is both impossible for the industry and an incongruous attempt to regulate health care providers through an insurance department. According to the experts in provider contracting, the majority of providers will not allow the contract revision and those that do will not comply with it. Therefore, insurers will have to pay all of these claims as in network without receiving the benefit of a discount. Because of this, any subcontracted providers that are in networks will drop out of networks they currently participate in. This will raise the cost of this type of care for consumers. Furthermore, there is noting in the statutes that contemplates this provision and thus, no authority to include it in this rule.

Recommendation – Delete Ins 9.32 (2)(c), Ins 9.32 (2)(e) and Ins 9.32 (2)(f) in its entirety. In addition, we suggest the legislature consider legislation that would enact the requirement of a disclosure of subcontracted services by providers to patients, with enforcement mechanisms on such providers.

6. Provider Directories and Appendix D. In Ins 9.32 (2)(d), the OCI has included a requirement that PPP's include in their provider directory a statement urging consumers to contact the PPP relative to the subcontracted providers (i.e.: Pathologist, Radiologist, etc.) to determine who is participating in the network. The statement must be written exactly as stated in Appendix D and must be in certain font size.

Summary – Most PPP's already have similar language in the directories notifying patients about these subcontracted providers. In addition, many of these PPP's operate in more than one state and have similar language on all of the directories they print. While WAPN does not object to including a provision warning consumers to contact the network first before seeking services from these subcontracted providers, we do object to the rigidness of the exact language requirement.

Recommendation – Change Ins 9.32 (2)(d) to read: *Include in its provider directory a prominent notice that substantially complies with Appendix D.*

7. Emergency Services Provision. In Ins 9.32 (2)(g), the OCI has included a requirement that PPP's treat emergency care as in-network, even if the service was performed out-of-network if the treatment was for a real emergency medical condition.

For reference, the provision relating to the treatment of emergency medical services is found in s.609.22 (6). Specifically, this provisions states:

609.22 Access standards. (6) EMERGENCY CARE. Notwithstanding s. 632.85, if a defined network plan provides coverage of emergency services, with respect to covered benefits, the defined network plan shall do all of the following: (a) Cover emergency medical services for which coverage is provided under the plan and that are obtained without prior authorization for the treatment of an emergency medical condition. (b) Cover emergency medical services or urgent care for which coverage is provided under the plan and that is provided to an individual who has coverage under the plan as a dependent child and who is a full-time student attending school outside of the geographic service area of the plan.

Summary – Most PPP's already pay the in-network benefit for emergency care at out-of-network facilities as patients in true emergent situations have neither the time nor ability to choose an in-network provider. While there appears to be no statutory authority to include such language in Ins 9, WAPN would agree to this language so long as the length of time of the care is included in the language. WAPN submitted sample language to the OCI that was used by Nebraska.

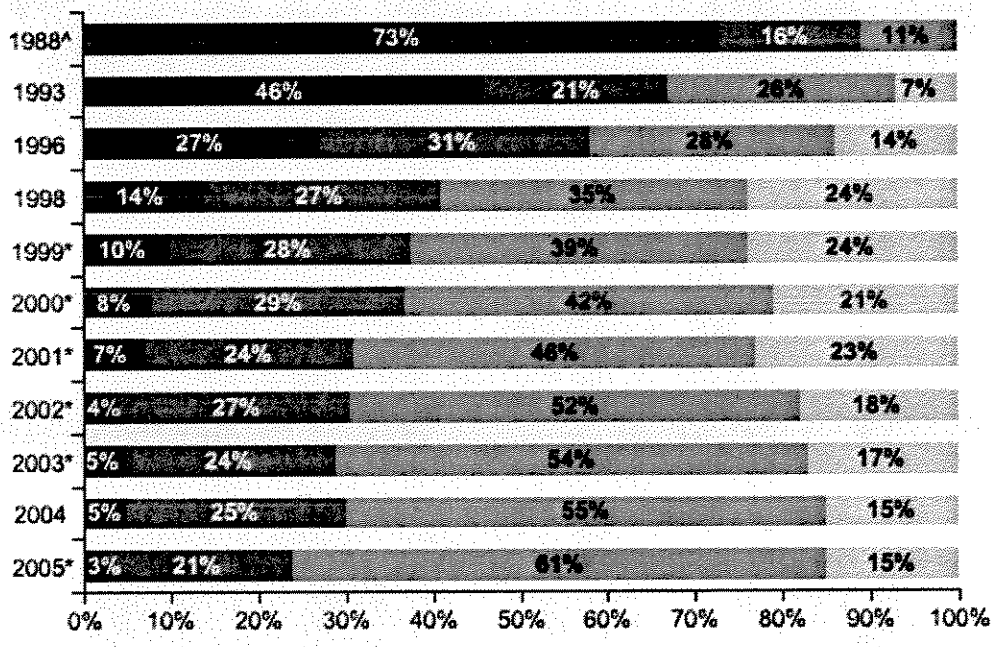
Recommendation – Add language to Ins 9.32 (2)(g) that states: *Emergency services mean health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition. Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability: (a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and (b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment.*

Conclusion – While WAPN has had other concerns with the various versions of the proposed revisions to Ins 9 over the past four years, we are willing to go forward with a regulation that addresses these core issues above. We urge the Committees to ensure the continued viability of PPP's in Wisconsin by ensuring the OCI adopts these above recommendations. We thank you for your consideration of our concerns.

KAISER FAMILY FOUNDATION | www.kff.org

Employer Health Benefits 2005 Annual Survey

Exhibit 5.1: Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2005



* Distribution is statistically different from the previous year shown at p<.05. No statistical tests were conducted for years prior to 1999.

^ Information was not obtained for POS plans in 1988.

Note: A portion of the change in enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey and removing federal workers from the weights. See the Survey Design and Methods section for additional information.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996, 1998; The Health Insurance Association of America (HIAA), 1988.

For more information regarding survey methodology, click here to view the Survey Design and Methods section.

KAISER FAMILY FOUNDATION | www.kff.org

Employer Health Benefits 2005 Annual Survey

Exhibit 5.2: Health Plan Enrollment, by Firm Size, Region, and Industry, 2005

	Conventional	*HMO*	*PPO*	*POS*
FIRM SIZE				
Small (3-24 Workers)	4%	13%*	57%	26%*
Small (25-49 Workers)	4	22	48*	26*
Small (50-199 Workers)	3	19	65	14
ALL SMALL FIRMS (3-199 Workers)	**3%**	**18%**	**58%**	**21%***
Midsize (200-999 Workers)	3	20	66	11
Large (1,000-4,999 Workers)	1*	23	67*	9*
Jumbo (5,000 or More Workers)	3	24	60	13
ALL LARGE FIRMS (200 or More Workers)	**3%**	**23%**	**63%**	**12%**
REGION				
Northeast	4%	23%	54%*	19%
Midwest	3	16*	70*	11
South	3	17*	66	14
West	2	32*	51*	15
INDUSTRY				
Mining/Construction/Wholesale	5%	13%*	66%	16%
Manufacturing	3	19	66	12
Transportation/Communications/Utility	3	20	71	6*
Retail	4	19	56	22
Finance	3	22	64	11
Service	2	22	56	20*
State/Local Government	3	35*	52	11
Health Care	2	20	69	10
ALL FIRM SIZES, REGIONS, AND INDUSTRIES	**3%**	**21%**	**61%**	**15%**

* Distribution is statistically different from All Firm Sizes, Regions, and Industries within a plan type at p<.05.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005.

For more information regarding survey methodology, click here to view the Survey Design and Methods section.

The Kaiser Family Foundation and Health Research and Educational Trust
Program Area: Health Care Marketplace Project | **Publication Date:** 09/14/2005

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Connie L. O'Connell
Commissioner

December 16, 1999

Legal Unit
121 East Wilson Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 267-9586 • Fax: (608) 264-6228
E-Mail: Legal@oci.state.wi.us
http://badger.state.wi.us/agencies/oci_home.htm

Mr. Daniel J. Schwartzer
Wisconsin Association
Of Health Underwriters
6441 Enterprise La.
Suite 102-A
Madison, WI 53719-1139

Re: Access to Providers

Dear Mr. Schwartzer:

Commissioner O'Connell asked that I respond to your letter of December 1, 1999, in which you ask for the Office's advice with respect to the application of s. 609.22, Wis. Stats., and s. INS 9.34, Wis. Adm. Code, as proposed in Clearing House Rule #98-183. You ask how an insurer would "demonstrate" compliance with those provisions.

Section 609.22, Wis. Stats., requires a managed care plan to include in its provider network a sufficient number of providers to meet the anticipated needs of enrollees. In addition it requires a managed care plan to ensure that each enrollee has adequate choice among participating providers and that participating providers are accessible and qualified. The proposed rule interprets s. 609.22, Wis. Stats., as permitting insurers to comply with its provider access requirements by establishing a provider network which its accessible with "reasonable" promptness. "Reasonable" will be evaluated by the Office in the context of all the circumstances, including the nature of the provider, the nature of the provider's services, and the insureds' need for the services. In addition, as stated in the proposed rule, hours of operation, waiting times, and availability of after hours care may reflect "usual practices" in the local area and availability may reflect the "usual" travel times in the community.

The Office anticipates an insurer will demonstrate compliance with this requirement by maintaining records showing its direct or indirect contractual arrangements with an adequate network of providers, that its contracts include provisions addressing the access issues discussed above, and that it is monitoring and enforcing the contractual provisions. The Office expects that the primary means of monitoring compliance with contractual provisions governing hours of operation, waiting times, and availability of after hours care will be prompt handling and monitoring of complaints, grievance and appeals and appropriate corrective action when deficiencies are identified.

In summary, the statute, s. 609.22, Wis. Stats., as interpreted by the proposed rule, anticipates that insurers will take reasonable measures to provide, and monitor access to, "in-network" providers. Thank you for the opportunity to clarify this issue.

Sincerely,

Fred Nepple
General Counsel

cc Commissioner Connie L. O'Connell

FN: fn

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor
Connie L. O'Connell
Commissioner

121 East Wilson Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: Information@oci.state.wi.us
http://badger.state.wi.us/agencies/oci/oci_home.htm

June 8, 2000

MR. DANIEL J SCHWARTZER
EXECUTIVE DIRECTOR
WISCONSIN ASSOCIATION OF PROVIDER NETWORKS
2810 CROSSROADS DRIVE, STE 3000
MADISON WI 53718

Re: Ins 9.34 Access Standards

Dear Mr. Schwartzer:

Thank you for your inquiry dated April 18, 2000. Your letter requests an opinion as to whether the sample contract provision noted in your letter would satisfy the requirements of s. Ins 9.34, Wis. Adm. Code.

The sample provision noted in your letter requires providers under contract to a network to treat all patients, regardless of insurance, similarly. However, s. Ins 9.34 requires all of the following:

> Ins 9.34 (2) Additional Requirements. An insurer offering a managed care plan shall have the capability to:
> (a) Provide covered benefits by plan providers with reasonable promptness with respect to geographic location, hours of operation, waiting times for appointments in providers 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.
> (b) Have sufficient number and type of plan providers to adequately deliver all covered services based on demographics and health status of current and expected enrollees served by the plan.
> (c) Provide 24-hour nationwide toll-free telephone access for its enrollees to the plan or to a participating provider for authorization for care which is covered by the plan.

The language submitted in your letter establishes that the contract with providers is to offer services to covered persons in accordance with "normal practices and procedures of the affected practice or hospital". However, the language you submitted does not require providers to adhere to usual practices in the local area with respect to waiting and travel times. Additionally, consistent with Ins 9.42, we would expect that an insurer would also have a procedure or mechanism to monitor provider compliance with the rule requirements.

I hope this responds to your concerns. Please contact me should you have further questions.

Sincerely,

Eileen Mallow
Assistant Deputy Commissioner

cc: Fred Nepple

Daniel J. Schwartzer
Executive Director

(608) 243-1007
Fax (608) 241-7790

2810 Crossroads Dr., Ste. 3000 • Madison, WI 53718

WAPN
WISCONSIN ASSOCIATION
OF PROVIDER NETWORKS

April 18, 2000

Commissioner Connie O'Connell
Office of the Commissioner of Insurance
State of Wisconsin
121 E. Wilson St.
Madison, WI 53703

Dear Commissioner O'Connell:

In some of our past conversations, I had indicated the possibility of several Preferred Provider Plans forming an association. I would like to inform you that four Wisconsin based provider network organizations have formed an association called the Wisconsin Association of Provider Networks (WAPN). I have been contracted to represent this organization as the Executive Director. Combined, our members represent nearly 1.4 million Wisconsin consumers, of which roughly 550,000 of those consumers are insured through fully insured plans and, thus covered under state insurance laws. In 1999, our members contracted for nearly $1.8 billion dollars in health care costs.

Our primary goal as an association is to ensure the continued viability of the products of our members so that consumers continue to have choices within the health insurance marketplace. As you know, Chapter 609 of the Wisconsin Statutes, and Ins 9 of the Wisconsin Administrative Code have raised some concerns on behalf of our members. Our concerns are regarding the Quality Assurance and Access Standards provisions. It is our opinion that these provisions include language which makes compliance extremely difficult relative to preferred provider plans. Based on the number of Wisconsin residents represented by WAPN members, this affects a significant portion of the marketplace.

WAPN is looking for both administrative and statutory solutions relative to our concerns. The purpose of my letter today is to continue to explore administrative solutions for Ins. 9.34. In our previous discussions, I had indicated that the contractual language found in most provider network agreements do not provide for control over the providers' operations. However, there is a provision in most of these agreements that require the provider to treat the plan's patient in the same manner as the provider would treat all of their patients. A sample of this type of language is as follows:

"The provider agrees to provide covered services to covered persons/subscribers/beneficiaries in accordance with the normal practices and procedures of the affected practice or hospital, and with the same standards and availability as offered to other patients."

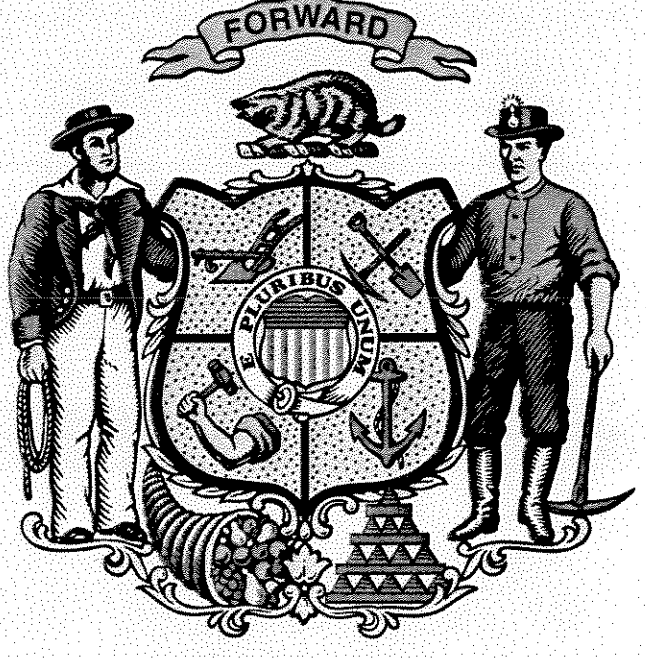
I would like to ask your opinion if the above provision, or language similar to the above provision, would satisfy the requirements of Ins 9.34. Please respond at your earliest convenience, and if you have any questions regarding my request, please do not hesitate to contact me.

Thank you for your consideration.

Sincerely,

Daniel J. Schwartzer
Executive Director

DJS/jlr


FORWARD
E PLURIBUS UNUM

PreferredOne

6105 Golden Hills Drive
Golden Valley, MN 55416

October 13, 2005

Delivered VIA Fax #608-241-7790 and U.S. Mail

Daniel J. Schwartzer, Executive Director
Wisconsin Association of Provider Networks
4600 American Parkway
EastPark One
Suite 208
Madison, WI 53718

RE: Wisconsin State Statute Chapter 609 and Regulation INS 9

Dear Mr. Schwartzer:

As you know, PreferredOne is a preeminent Minnesota preferred provider organization that has been in operation in Minnesota, North Dakota, South Dakota, Iowa, and Wisconsin since 1984. In Wisconsin, we have established networks of providers in those counties along the Minnesota-Wisconsin border delineated primarily by the St. Croix and Mississippi Rivers. These networks of Wisconsin providers essentially serve those Wisconsin residents whose employers are principally officed and actively engaged in the operation of their businesses in the State of Minnesota.

I write at this time to express PreferredOne's strong support of WAPN's March 2005 Position Statement and it's ongoing efforts to effect changes to current regulation INS 9 which will bring that regulation into conformity with Wisconsin State Statute Chapter 609.

PreferredOne had welcomed the important changes made to Chapter 609 by the 2001-2002 budget bill. However, PreferredOne finds it virtually impossible as a preferred provider organization to comply with regulation INS 9 as it is presently interpreted and enforced by the Office of the Commissioner of Insurance of your state. This is especially true with respect to the subject of Access Standards and the management of the quality of care rendered by our network providers. Access Standards designed for HMO plans are not appropriate for application to preferred provider organization plans. Likewise, the application of quality assurance and care management provisions intended for HMOs is not appropriate for preferred provider organizations where such quality and care management decisions are left to the respective providers and their patients.

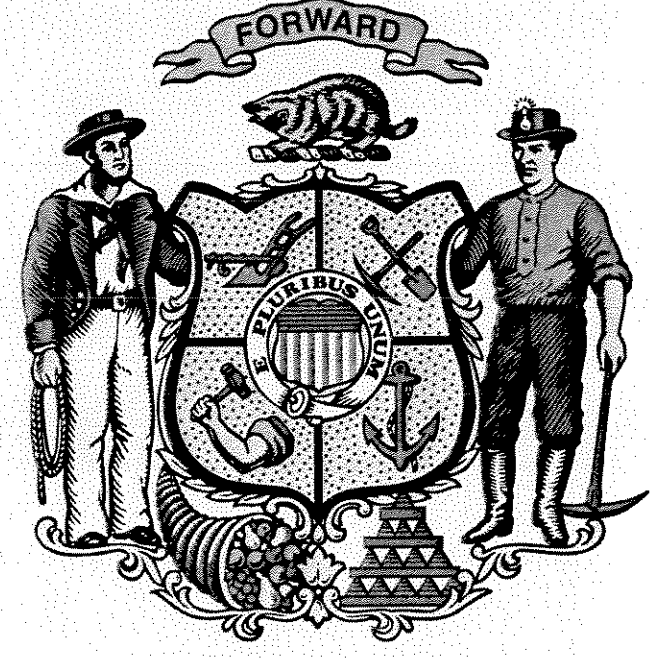
Accordingly, PreferredOne supports WAPN and its efforts to encourage the Wisconsin Senate and the Wisconsin Assembly to see that the changes being made by the Office of the Commissioner of Insurance to Regulation INS 9 are consistent with the legislative intent of Chapter 609 and bring the application and enforcement of INS 9 into conformity with the provisions of Chapter 609.

Good luck to you in this endeavor. If you need additional support in your efforts, please do not hesitate to contact us.

Very truly yours,

Michael T. McKim
Senior Vice President
General Counsel
763-847-3573
michael.mckim@preferredone.com

MTM/blf
T:\mike\WI statute 609


FORWARD
E PLURIBUS UNUM

The Council for Affordable Health Insurance

Council for Affordable Health Insurance

10-13-2005

Thank you for the opportunity to testify on the proposed rule, INS 9. My name is J.P. Wieske and I represent the Council for Affordable Health Insurance.

CAHI is a research and advocacy association founded in 1992. Our members include insurance carriers, discount medical plans, trade organizations, actuaries, doctors, agents, and others. We share a common interest in promoting free-market solutions to America's health care problems.

CAHI has been an active and regular participant in the discussions held by the OCI on the INS 9 rule. Meetings were held, and the issues were discussed in some detail.

We heartily commend the OCI for the process, and the overall level of discourse.

Unfortunately, we can not commend the outcome.

This was not a give and take discussion or a negotiation – at least not the discussions I attended. The commissioner certainly listened to some concerns – but plowed ahead on others regardless of the concerns.

This rule reflects a narrow-minded focus that ignores cost drivers, but instead focuses on the narrow issue of out-of-pocket costs.

Perhaps the most telling example of this narrow-minded focus is what the commissioner proposes to do with out-of-network providers. They have crafted a solution that only a government bureaucrat could love.

In order to solve the problem of PARE doctors – typically hospital-based physicians like pathologists, anesthesiologists, radiologists, and emergency room physicians – the commissioner proposes a solution that ensures they have no incentive to join any network.

Let me explain the results of this bureaucratic proposal – but listen close because it is complicated!

The commissioner's proposal requires

1. The insurer to amend every contract with all preferred providers
2. The new contract requires the treating physician to take charge in understanding every patient's insurance arrangement, and to be PERSONALLY responsible for ensuring the patient will not see out-of-network providers.
3. The treating physician will schedule with all providers to ensure that network physicians are used.
4. Treating physicians must document this effort.
5. Insurance companies must ensure the physicians comply with the requirement.
6. Claims without documentation must be paid at the in-network benefit level.

112 S. West Street, Suite 400, Alexandria, VA 22314 ◆ Phone: (703) 836-6200 ◆ Fax: (703) 836-6550
E-mail: jpwieske@cahi.org ◆ Web Site: www.cahi.org

7. Since the documentation will not be included with the claims, the provision will SUBSTANTIALLY increase appeals.

This provisions is hugely problematic because it violates many good government provisions:

1. It is impossible to track
2. It is impossible for a company to ensure compliance
3. It is administratively costly
4. It overburdens doctors with responsibilities that should not be theirs
5. It creates new problems for contracting providers
6. It creates payment problems
7. It provides little clarity for consumers on important payment issues.

Even more problematic is the fact that there is no statutory basis for this provision. No state has enacted such a complicated and unworkable proposal for dealing with this problem.

Alternatively, the Commissioner has proposed an administrative simple solution to the issue of emergency room coverage. Without passage of a statute from this body, he proposes to force the insurance carrier to cover all emergency room care as in-network. The last I heard, only the legislature has the ability to pass a new mandated benefit.

There are other provisions which may seem reasonable on the surface, but create other problems. For example, the commissioner has moved significantly on the plan design issues. The current proposal allows PPO carriers to sell plans that have out-of-network coinsurance of 50%, and an out-of-network deductible two times greater than the in-network deductible.

This proposal meets most of the market's requirements for plan designs. The number of plans that will need to be changed to meet these new requirements is relatively small. However, in the absence of legislative action, is it appropriate for the OCI to create its own standards? Is it good public policy to create a standard that can be revised again and again by rule? Is it a good idea to create a complicated approach that tests all layers of plan design?

While the plan design issue is a theoretical problem, the discriminatory PPO-only notice is a real one. The commissioner proposes a sort of PPO warning notice – similar to the "Buyer Beware" PPO press release from last year. The notice is triggered based on plan design, but does not apply to potentially more restrictive HMO and point of service plans. The warning label is intended to notify buyers of potential restrictions in coverage.

At CAHI, we have always supported increased disclosure. You may be aware of our efforts nationally on hospital price disclosure. The same concept applies here. We support disclosure – provided it is applied equally across the market and without discrimination. Unfortunately, the arbitrary standards contained in this rule make little sense. We would propose that these warning labels be struck or applied to all plans – including HMO and Point of Service plans.

I would also like to briefly highlight a few other issues with this rule.

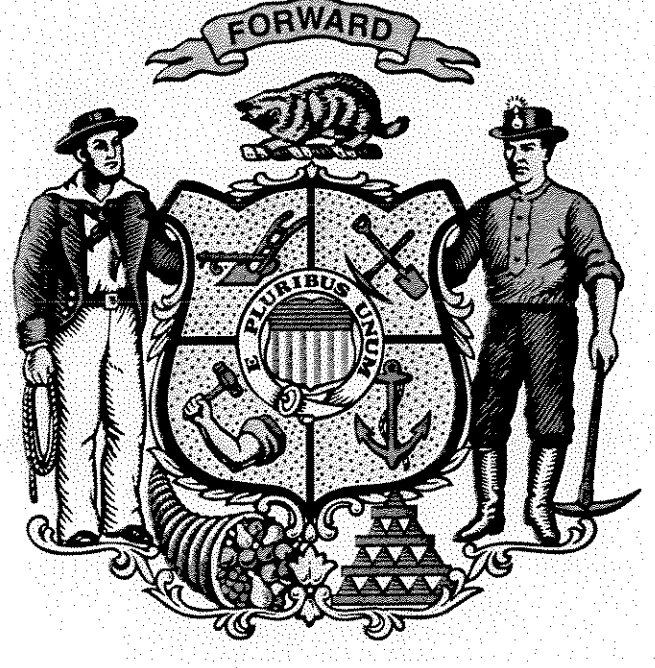
1. Access Standards – The PPO association understands this issue far better and should be respected for their fight on this issue. Too often I have seen companies dismiss these kinds of

concerns in other states only to find that they face considerable fines later when the state conducts a market conduct examination.

2. Limited Scope Plans – We have no member interest in this provision, but it makes little sense to apply this rule to dental and vision plans. This provision is new to this version of the rule, and we do not understand it.
3. PPP definition – This provision continues to contain policy items and should be modified.

In closing, the OCI has released a rule that creates poor public policy, creates compliance issues, increases health insurance costs, and will lead to increased confusion in the marketplace. We hope this public testimony can be a springboard for the OCI to reconsider many of their new and more questionable provisions. We agree the OCI has addressed a few of the issues of concern, but the new provisions create many new problems.

Thank you for the opportunity to testify, and I would be happy to address any questions you may have.


FORWARD
E PLURIBUS UNUM

WISCONSIN ASSOCIATION OF HEALTH UNDERWRITERS

Wisconsin's Benefit Specialists

Senate and Assembly

Joint Public Hearing

Committee on Agriculture and Insurance

Clearinghouse Rule 05-059

October 13, 2005

We would like to thank the members of the Committees for allowing us to provide written comments on the above referenced regulation. The members of the Wisconsin Association of Health Underwriters (WAHU) and National Association of Health Underwriters (NAHU) are comprised of insurance professionals involved in the sale and service of health benefits, long-term care benefits, and other related products, serving the insurance needs of over 100 million Americans. We have almost 18,000 members around the country and nearly 600 members here in Wisconsin. Our membership is primarily made up of insurance agents that work directly for and with the consumers of health care. Since our number one concern is our customers, we consider ourselves to be consumer advocates and look at how any legislation or regulation will affect these customers.

In reviewing Clearinghouse Rule 05-059, we respectfully oppose this regulation. It is our understanding that the changes to the existing regulation, known as Ins 9, were necessary based on statutory changes made to Chapter 609. While we supported those changes made to Chapter 609, we oppose the proposed regulation, as it appears to ignore the intent behind the provisions contained within 2001 Wisconsin Act 16.

Our members work with both individuals and employers on developing plan designs that best suit the consumer's needs. In the past few years, there has been a demand by consumers for consumer driven type plan designs, including higher deductibles and higher co-insurance limits. This proposed regulation removes, and reduces at best, the consumer's flexibility in benefit design. This is not a benefit to the consumer. It is more government intervention that actually ends up hurting the consumer in the end. In working with Employers, agents often attempt to reduce the increase in health insurance renewals through plan design. To limit this plan design takes away the consumers ability to afford health care coverage.

As experts in the financing of health care, we are also fearful that this proposed regulation will at best, cause increases in PPO premiums, or at worst case, cause many insurers to no longer offer their PPO product based on provisions that will be impossible for the PPO's to comply with. Such examples include your proposed Ins 9.32 (2)(a) and Ins 9.32 (2)(c). Both of these provisions require a PPO to have contractual control over the business operations of a health care provider.

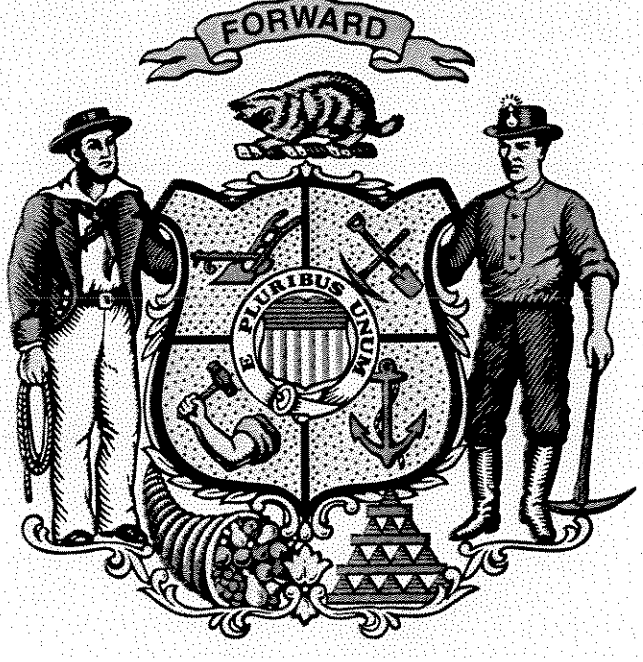
The consumers our members serve have made it very clear that they do not want this type of oversight by their health plan. PPO plans have been growing over the last decade specifically because consumers do not want their health plan interfering with the care provided by their doctors. Furthermore, doctors have also expressed their desire to no longer enter into network arrangements that would give up control over their operations to health plans. These two provisions would directly interfere with the wishes and desires of both the consumer and the providers. Without this ability to control the providers' operation, many insurers may decide to simply not offer the PPO product in the marketplace. This reduces competition, removes choice for consumers and will ultimately lead to higher health care costs, and thus higher insurance premiums.

Another concern we have is Ins 9.25 (5). In this provision you require a PPO to include language warning the consumer of limited out of network benefits. This language is confusing and will only induce a sense of an inferior product, which often times would not be accurate. We also feel it is discriminatory and misleading to the consumers our members serve. HMO benefits often include no coverage for out of network providers and yet you require only PPO's to include this language. This appears to favor one type of plan over another and we believe consumers, and the agents that work with them, are in the best position to make this type of determination. WAHU fully supports all plan designs and the right of the consumer to chose among them.

Finally, we also have concern with the attempt to include dental and vision plans in this regulation. Managed care in health plans is completely different than managed care in dental and vision plans. Steerage in these ancillary products is designed and utilized differently than in health plans and thus inclusion of these ancillary products is unnecessary and overly burdensome.

We hope that the committee will be able to have the OCI made the needed changes to this regulation in order to preserve both HMO and PPO plans as viable options for Wisconsin consumers, rather than favor one plan over another and attempt to reduce PPO participation. We thank you for the opportunity to provide our comments and would be happy to discuss our concerns in more detail if you desire.

Wisconsin Association of Health Underwriters
608-268-0200
www.eWAHU.org
LegComm@eWAHU.org


FORWARD
E PLURIBUS UNUM

Assembly Insurance Committee
and
Senate Agriculture and Insurance Committee Hearing
Clearinghouse Rule 05-059
[Revisions to INS 9]

Joint Statement by
Blue Cross Blue Shield of Wisconsin,
Humana Insurance Company,
WEA Insurance Trust and
Wisconsin Physician Service Insurance Corporation

We are among the largest insurers in the state providing coverage to over 30 percent of all Wisconsin health insurance consumers. As Wisconsin Association of Life and Health Insurers (WALHI) members, our companies participated in the long and exhaustive discussions with the Office of the Commissioner of Insurance on the rule.

We had major concerns with the proposed rule that the Office of the Commissioner of Insurance advanced to begin this process. We appreciate the willingness of Commissioner Gomez and the office staff to engage in discussions in an effort to clarify and resolve concerns and issues raised with the original proposal. Those working sessions were productive in resolving most issues. The proposed rule that was submitted to the Legislature is substantially better than the original proposal. We believe the final rule strikes a workable balance on a wide variety of issues within the state's health insurance marketplace.

*Blue Cross Blue Shield of Wisconsin is an independent Licensee of the Blue Cross Blue Shield Association.

Therefore, **our companies support adoption of this rule in its current form.**

Contacts:

Karen Geiger, Counsel II
Blue Cross Blue Shield of Wisconsin
414-226-5956
karen.geiger@bcbswi.com

Allan Patek, Government Relations Director
Humana
920-337-5618
apatek@humana.com

Vaughn L. Vance, Director of Government Relations
WEA Trust Contact
608-661-6774
vvance@weatrust.com

Christine A. Russell, Vice President, Government Relations
Wisconsin Physicians Service Insurance Corporation
608-221-7162
Christine.Russell@wpsic.com

October 13, 2005