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_pt02**

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

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

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

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

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

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

W.A.L.H.I.

Wisconsin Association of Life & Health Insurers

Memorandum

DATE: October 13, 2005
TO: Committee Chairs and Members of the Senate and Assembly Insurance Committees
FROM: Pat Osborne, on behalf of the Wisconsin Association of Life & Health Insurers (WALHI)
RE: Comments on Clearinghouse Rule 05-059

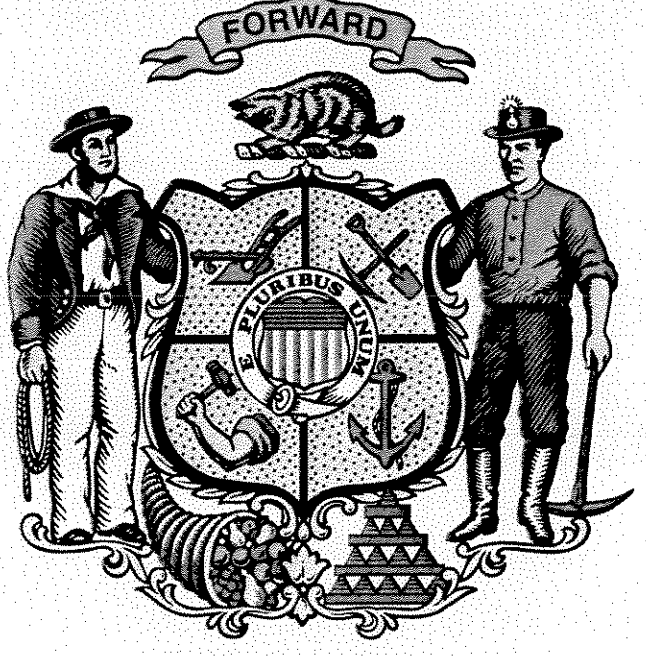
The Wisconsin Association of Life and Health Insurers (WALHI) appreciates the opportunity to provide comment on OCI proposed rules relating to defined network plans and preferred provider plans. We would first like to recognize and commend the Commissioner and his staff for the process and the hard work that went into the development of this rule package. WALHI and its member companies participated in numerous working sessions conducted by the Commissioner in an attempt to clarify issues and narrow policy differences. We believe the working sessions were productive in that regard and resulted in a draft rule before you today that is considerably improved over the discussion draft issued by OCI in October of 2004.

I am appearing today neither for or against the proposed rule. WALHI is a trade association comprised of numerous companies with diverse business operations and, despite improvements in the rule, not all member companies are satisfied with all of the provisions. I anticipate you will hear from individual member companies regarding their respective positions on the rule.

There is one issue I would like to briefly comment on from an association perspective. That issue pertains to provider contracting and is covered under Ins 9.32 (2) (c) through (f), which requires an insurer offering a preferred provider plan to include in all participating provider contracts a clause requiring the provider to disclose, to the enrollee, whether nonparticipating providers may be involved in the delivery of care. We support the concept of this provision and recognize that it represents a compromise in comparison to a more onerous approach contained in OCI's October 20, 2004 discussion draft rule. However, we believe that the ancillary provider issue is better addressed through a statutory change rather than a contracting requirement in the administrative code. From our perspective, such statute should require not only the disclosure of ancillary health care providers, but should also ensure that enrollees are provided with a good-faith, timely estimate of charges.

Thank you for your consideration.

22 North Carroll Street • Suite 380 • Madison, WI 53703 • (608) 258-1770 • FAX (608) 258-1753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NFIB
The Voice of Small Business®

WISCONSIN

Statement Before the
Senate Committee on Agriculture and Insurance
And
Assembly Committee on Insurance

By

Bill G. Smith
State Director
National Federation of Independent Business
Wisconsin Chapter

Thursday, October 13, 2005
Clearinghouse Rule 05-059

Senator Kapanke, Representative Nischke and members of the committee, I appreciate the opportunity to participate in today's hearing for Clearinghouse Rule 05-059.

As you know, the cost and availability of health insurance has been a top issue of concern by our state's small business owners for many years. Since 1986, according to NFIB's Problems and Priorities Studies, the cost of health insurance has been ranked by small business owners as their number one concern.

Obviously, whenever there is a proposal that may impact the cost of health insurance we give that issue our closest attention.

Two years ago, we were very pleased the Legislature approved and the Governor signed into law the Small Business Regulatory Fairness Act. This bill was necessary because the 1983 Regulatory Flexibility Act, a small business regulatory relief proposal, was essentially being ignored by most state agencies.

The Small Business Regulatory Fairness Act (Act 145), includes a process to assist agencies and promote greater compliance with the requirements of regulatory flexibility.

Specifically, the Act requires any state agency that proposes or revises a rule that may have an impact on small business to consider methods that will reduce that impact.

The Office of the Insurance Commissioner has concluded this rule will affect just one small business, a Limited Service Health Organization, and according to the initial regulatory flexibility analysis, the rule will not have a significant economic impact on that one insurer.

However, as representatives of the insurance industry have/will testify, this rule proposal may have an impact on the cost of health coverage for those firms enrolled in a PPO plan.

That potential cost impact for small business is what brings me to the hearing this afternoon. More than a third of our members are enrolled in a PPO plan – no other type of coverage is even close to the popularity of PPOs. Historically, PPO plans have satisfied consumer demands for lower cost health coverage options along with greater choice of health care providers.

Although the Insurance Commissioner analysis concludes the rule will not impact a significant number of small businesses, we disagree.

If 32 percent or 4000 of our members are enrolled in a PPO plan, and these firms employ, on average, ten workers, that means 40,000 people will be impacted by any revision in the law or regulatory process that will effect the cost of PPO plans.

The Small Business Regulatory Fairness Act requires the referral of any rule that may have a significant economic impact on small business to the Small Business Regulatory Review Board.

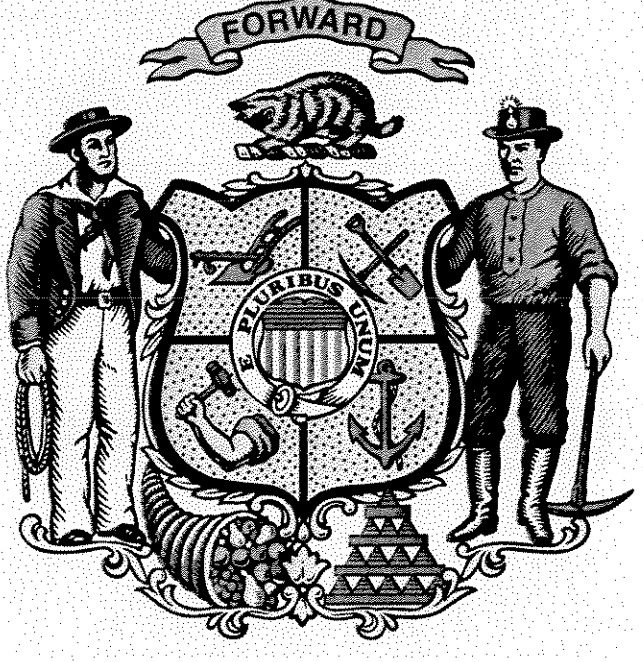
I am not here to speak on the merits of this rule proposal, and my testimony should not be interpreted as opposition to content or intent of the Commissioner in proposing the rule. That debate can occur among others. We are here on the issue of process.

We recognize one may conclude the revisions to Ins. 9 may not have a direct impact on small business, however, we believe it is good public policy and consistent with the spirit of small business regulatory flexibility to perform the analysis even when the regulation has an indirect impact.

We believe the rule will have both a direct and indirect impact on thousands of small business owners – some who sell and some who purchase PPO plans.

Accordingly, we request the rule be returned to the Office of the Commissioner of Insurance. A small business impact analysis can be prepared, and submitted to the Small Business Regulatory Review Board, which will make a determination whether the rule has been properly reviewed and analyzed for it's impact on small business.

Thank you.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Summary of Testimony for Clearinghouse Rule 05-059
October 13, 2005

Thank you for the opportunity to provide testimony on Clearinghouse Rule 05-059. This is my first opportunity to provide testimony in a setting like this, and I consider it a privilege to appear before you today.

My name is Paul Sabin. I am the Vice President of Network Development for HealthEOS by Multiplan, a Preferred Provider Organization (PPO) based in Brookfield, Wisconsin. In this role, I am responsible for provider contracting and for maintaining provider networks so that patients can access health care services from the many qualified health care professionals, hospitals, and ancillary facilities throughout the state. Prior to my current role, I worked as the Vice President-Managed Care for Covenant Healthcare System in Milwaukee, Wisconsin. My employment at this major health care provider system, along with my current role has allowed me to gain valuable insight and experience on some of the issues before us today. It has further provided me with the opportunity to examine the issues from both sides of the negotiating table – from the provider side and the network side.

I certainly have a number of concerns with the proposed regulations. In addition to the areas I will address in some detail in a moment, I have concern with mandating specific coverage levels at a time when there is a lot of experimentation in the marketplace. This experimentation is taking place in an effort to find an effective mix of adequate coverage for patients while requiring them to become more actively involved in the decisions they make. It seems to me that we should allow this experimentation process to take place, free from excessive intervention, for a reasonable period of time to see whether there is a positive impact.

Not surprisingly, most of my detailed comments today pertain to two (2) areas. These areas include the so-called "Access Standards" as well as the "Ancillary Providers" issue. By the term Ancillary Providers, I am referring to anesthesiologists, emergency department physicians, radiologists, and pathologists. I emphasize these specific areas because the proposed regulation imposes requirements on PPOs through the provider contracting process.

In general, the provider contracting process is a difficult, time-consuming endeavor. It is not uncommon for discussions with large, sophisticated provider systems, clinics, and hospitals to take a full year to complete. Adding provisions to an already complex and lengthy negotiation process will only make it more difficult and contentious, especially considering the subjects that are being proposed.

Access Standards

With respect to Access Standards (Ins9.32 (2)(a) and Ins 9.32 (2)(b)), the proposed regulation appears to ask us, through the use of the provider contracting process, to regulate behavior on behalf of the provider community. As we work with physician

offices, hospitals and so forth throughout the state, we are dealing with literally thousands of independent organizations, each with their own particular way of conducting business. These organizations, for the most part should be free to serve the market as they see fit. Asking us to regulate business practices in areas such as hours of operation, waiting times, and after hours care will place us in a constant state of conflict with the provider community over these topics. Just negotiating these topics would be very difficult, but forcing providers by contract terms to comply with a rigid standard would make this process impossible.

Even if we were able to achieve the desired effect of this regulation, we would not be in a good position to monitor and comply with the provisions. Our clients, the ultimate payors of health care services would be penalized for actions or inactions of independent organizations making decisions in the marketplace in accord with their own interests. This is simply too much risk to have for a payor, and it is not possible to achieve as a PPO.

If regulation of hours of operation, waiting times, and after hours care throughout the state is a good idea – and I am not convinced at this point that it is – it would be better to do so by law or by regulation directly with those entities rather than to require that of us, as a PPO working on a provider contract with these providers.

This proposal is too far-reaching, it is too difficult to monitor, and there is too much risk for the ultimate payors of health care services for which they have limited or no control.

Ancillary Providers

As for Ancillary Providers (Ins 9.32 (2)(c), Ins 9.32 (2)(e), and Ins 9.32 (2)(f)), I acknowledge that this is a difficult issue for patients. We are discussing, of course, patients receiving care at an appropriate in-plan facility to receive care and maximize insurance coverage only to find out that certain specialists involved in the case (anesthesiologists, radiologists, pathologists and emergency department physicians) are not in the plan. This forces higher out-of-pocket expense for patients. Please note that most of these physicians work with things and not patients. They administer anesthesia, they read images, and they test and analyze blood and specimens. At times, services are performed by physicians who have never had a one-on-one interaction with the patient. I have witnessed this issue from all sides, as a PPO representative dealing with members, as a provider dealing with angry patients, and as a patient.

The proposed regulation is not workable in my view. It requires again that we use provider contracts to regulate behavior, and again it penalizes the ultimate payor of health care services for any mishaps.

This regulation is directed at the wrong place. Given the structure of exclusive agreements that ancillary providers have with hospitals and other facilities, other parties ought to be responsible for addressing this issue.

Ancillary providers, with whom provider contracting is already very difficult, will become even more problematic if these providers know that by not reaching agreement with PPOs, they will still be treated as in-plan providers. We are, through this regulation, creating a condition for them *not* to reach agreement with us. This will have the effect of increasing costs in this state at a time when health care costs in general and physician costs in particular are high relative to other states.

Again, I certainly acknowledge the frustrating nature of this issue. I just question the methods proposed to address it. Other alternatives should be explored and carefully analyzed. This proposal does not represent the ultimate solution.

I would be pleased to discuss these matters in greater detail and to address any questions you may have. Thank you for the opportunity to share my thoughts with you.

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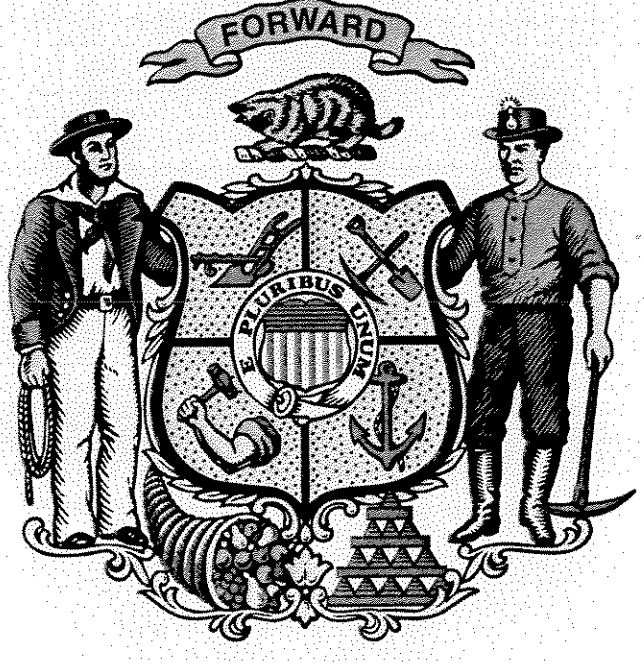
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WISCONSIN HOSPITAL ASSOCIATION, INC.

October 13, 2005

To: Members, Senate Committee on Agriculture and Insurance
Members, Assembly Committee on Insurance

From: Eric Borgerding, Senior Vice President
Laura Leitch, Vice President and General Counsel

Re: Comments on Clearinghouse Rule No. 05-059

The Wisconsin Hospital Association appreciates that the Assembly Insurance Committee is holding a hearing on Clearinghouse Rule No. 05-059, the proposed amendments to INS 9.

WHA understands that the amendments to INS 9 have been under consideration, debated, and changed several times over the last several years. The final product, unfortunately, includes a provision to which WHA must object.

Proposed INS 9.32(1) requires an insurer offering a preferred provider plan to include in its contracts with participating providers a provision requiring the provider that schedules non-emergency care to give a patient, who is in the insurer's network, the name of each provider that will or may participate in the delivery of care and whether each provider is a participating or nonparticipating provider in the insurer's network.

WHA objects to this provision for a number of reasons:

- The provision suggests that providers are better positioned than the insurers themselves to advise insured members of the details of their policy. This is plainly not true and such a provision is incongruous in an administrative rule the goal of which is to protect insurance consumers. If insurers are claiming they are unable to accurately advise their members about how their policy works, there is a serious consumer protection issue to be addressed.

- It is not practical because hospitals cannot possibly know all of the contracts entered into by insurers. An insurer would know whether it has a contract with a specific provider. It should be incumbent upon the insurer to inform its enrollee whether there is a possibility that some providers might not be covered by the plan purchased from the insurer by the enrollee.

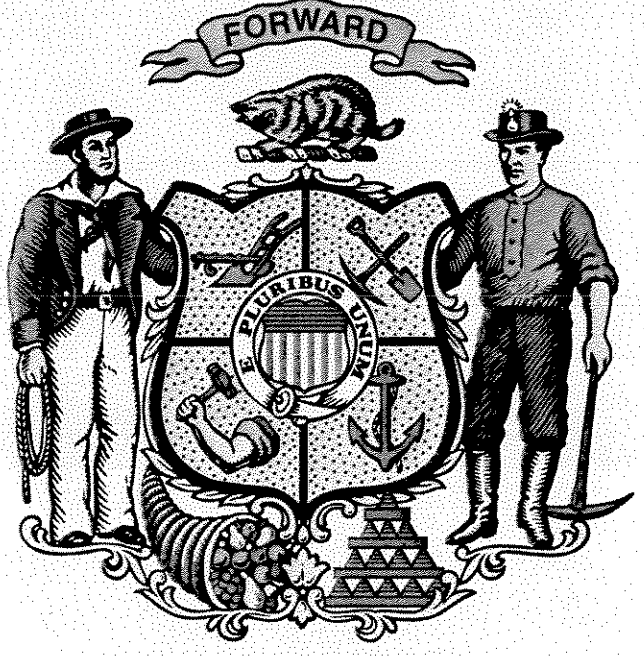
- The rule would put into law what should be a negotiated contract term. It certainly is not clear that the proposed required contract provision is the best solution to the identified problem. It makes more sense for the insurer and the providers to negotiate contracted solutions that best fit the particular circumstances of the community, provider, and insurer.

- OCI does not have the authority to regulate providers. By requiring contracts between insurers and providers to include a specific term, OCI is regulating providers without the supporting statutory authority.
- WHA is concerned about patient reliance. Hospital staff scheduling the appointment with the patient might not have current information about contracts that the patient's insurer might have (or not have) with various providers.

- It is not practical because a course of treatment is not always known. A hospital, for example, cannot possibly know all of the providers who *may* participate in the delivery of care to the patient. Surgical patients, for example, might require different procedures and providers depending on the course of the surgery.

The proposed rule requires insurers to notify their enrollees that their benefits might be limited if the enrollee uses a nonparticipating provider. If an insurer would like its participating providers to provide the insurer's enrollees with more information, that extra service should be part of the contract negotiations and not part of the rulemaking process that was directed by the legislature to regulate insurers, not providers.

Thank you for the opportunity to comment on this rule.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Wisconsin Auto and Truck Dealers
Insurance Corporation

150 E. Gilman Street—Level A
Madison, WI 53703
(608) 251-0044 Fax: (608) 251-4379

Mailing Address:
P.O. Box 5345, Madison, WI 53705-0345

Re: Ins 9, CR05059
Position: Oppose as written

Dear Senator Kapanki, Representative Nischke, and Senate & Assembly Insurance Committee Members,

Good afternoon, my name is Lee Bauman. I am the President of the Wisconsin Automobile & Truck Dealers Insurance Corporation. We provide group health insurance coverage to over 200 dealerships and nearly 10,000 participants in the state of Wisconsin. We have been providing health insurance benefits to our members for over 50 years. It is extremely important for our members to continue to purchase affordable insurance coverage through our plan.

We are organized as a Preferred Provider Organization (PPO), or more specifically a Preferred Provider Plan (PPP) as defined in the regulations. We are a member of the Wisconsin Association of Life and Health Insurers, and we believe that specific provisions in Ins 9 are detrimental to the PPO market and are not intended by the legislature. We are concerned that overly restrictive regulations could eliminate PPOs from the marketplace at a time when more plans and more solutions are needed for our members. Our areas of concern are as follows:

1. Access Standards – Preferred Provider Plans (PPPs) should be removed from the Access Standards. PPPs do not have control over provider operations. We do not and should not make decisions for providers regarding hours of operation and waiting times for appointments.

2. Pre-authorization provisions – We commonly use utilization management tools, such as hospital pre-authorizations. We recommend that Ins 9.25(4) be deleted in its entirety. This provision provides regulations that exceed statutory authority on hospital pre-authorizations.

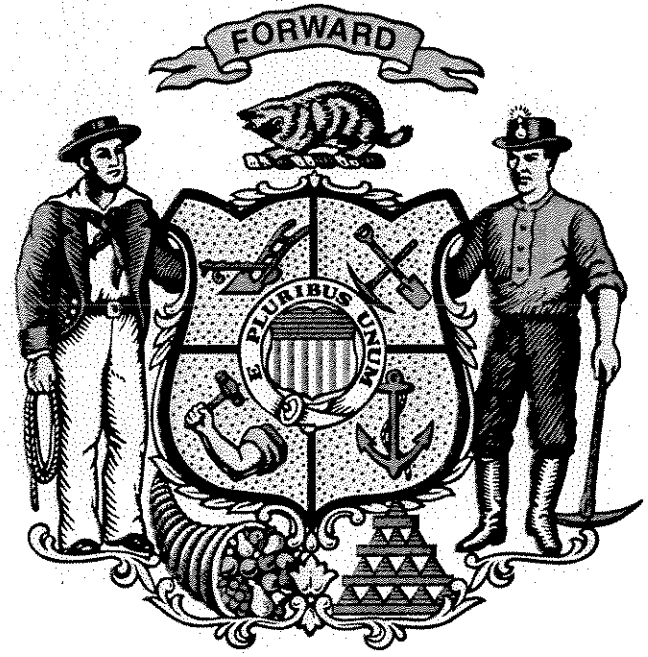
3. Requirement that insurers require providers to disclose subcontracted services (i.e., pathologists, radiologists, etc.). This is impractical if not impossible for PPPs. It seems much more logical for providers to disclose subcontracted services to patients.

We believe that Preferred Provider Plans, or PPPs such as our own plan, are legitimate plans that need to compete on a level playing field with other plans. The legislature has recognized PPPs as important insurance plans and we need to develop the rule to reflect this emphasis.

Thank you for listening to our concerns. We would be happy to provide further input on any of these important issues.

Sincerely,

Lee Bauman
President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LCRC FORM 2

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Ronald Sklansky
Clearinghouse Director

Richard Sweet
Clearinghouse Assistant Director

Terry C. Anderson
Legislative Council Director

Laura D. Rose
Legislative Council Deputy Director

CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

CLEARINGHOUSE RULE **05-059**

AN ORDER to repeal Ins 9.30; to renumber Ins 3.67 (1) (b), (c) and (e), 9.01 (5) to (12) and 9.34 (2) (intro.), (a) to (c); to renumber and amend Ins 3.67 (1) (a) and (d), 9.01 (4) and (6), 9.30 and 9.31; to amend Ins 3.67 (4), chapter Ins 9 (title), 9.01 (intro.), (3), (13), (15), (17) (intro.), (a) and (c), 9.07 (1), subchapter III (title) of chapter Ins 9, 9.35, 9.36, 9.37, 9.38 (intro.), (4) (intro.) and (c), 9.39 (4), 9.40 (title), (1) (c), (2), (3), (4), (6), (7) (intro.) and (8), 9.42 (1), (2), (3), (4) (intro.), (a) and (e) and (5) (a) and 18.03 (2) (c) 1.; to repeal and recreate Ins 9.34; and to create Ins 9.01 (9m), (10m) and (14m), 9.32, 9.325, 9.33, 9.41, 9.42 (9) and Appendix D, relating to revising requirements for insurers offering defined network plans, preferred provider plans, and limited service health organization plans in order to comply with recent changes in state laws and affecting small businesses.

Submitted by **INSURANCE COMMISSIONER**

06-15-2005 RECEIVED BY LEGISLATIVE COUNCIL.

07-13-2005 REPORT SENT TO AGENCY.

RS:JLK

LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

This rule has been reviewed by the Rules Clearinghouse. Based on that review, comments are reported as noted below:

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]

   Comment Attached YES ☐ NO ☑

2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]

   Comment Attached YES ☑ NO ☐

3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]

   Comment Attached YES ☐ NO ☑

4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]

   Comment Attached YES ☑ NO ☐

5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]

   Comment Attached YES ☑ NO ☐

6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]

   Comment Attached YES ☐ NO ☑

7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]

   Comment Attached YES ☐ NO ☑

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Ronald Sklansky
Clearinghouse Director

Richard Sweet
Clearinghouse Assistant Director

Terry C. Anderson
Legislative Council Director

Laura D. Rose
Legislative Council Deputy Director

CLEARINGHOUSE RULE 05-059

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated January 2005.]

2. Form, Style and Placement in Administrative Code

a. SECTION 1 renumbers many paragraphs in s. Ins 3.67 (1). It would cause less disruption if renumbering were minimized by simply renumbering (e) to (a) and (a) to (am). Also, ", as renumbered," should be inserted preceding the last reference to "s. 3.67 (1) (a)" in the treatment clause. Both comments also apply to SECTIONS 5 and 11. (For example, in SECTION 5, the only renumbering necessary is renumbering (12) to (3m).)

b. The treatment clause in SECTION 2 should refer only to s. Ins 3.67 (4) (intro.) as that is all that is being amended.

c. In s. Ins 3.67 (4), the notation "sub." should be replaced by "subs." and the reference to "s. 18.03" should be changed to "s. Ins 18.03." [s. 1.07 (2), Manual.]

d. When a rule is amended, language to be removed is stricken-through and new material is underscored. The new underscored material always immediately ***follows*** the over-stricken material. [See s. 1.06 (1), Manual.] The rule has many examples of failure to follow this protocol, including: ss. Ins 9.01 (3), 9.07 (1), 9.30 (intro.), 9.31 (2) (intro.), 9.35 (1) (intro.), (a) 1., 2., and 3., and (b) 1., (2) (intro.), and (3) (intro.), 9.36 (1) and (2), 9.38 (4) (c), 9.40 (4), 9.42 (1), and 9.42 (5) (a). The entire rule should be carefully reviewed for this problem.

e. In s. Ins 9.01 (9m), (10m), and (14m), the phrase ", for purposes of this chapter," should be deleted as s. Ins 9.01 (intro.) already makes clear that the definitions apply for ch. Ins 9.

f. In s. Ins 9.01 (13), "~~plan preferred provider plan or limited service health organization~~" should be deleted. That language is not in the current rule and should not be shown as material that is being removed. [See s. 1.06 (1), Manual.] The same comment applies to the following: "~~directly or indirectly~~" in s. Ins 9.01 (15); the second use of "~~s. 609.01 (4), Stats.,~~" in s. Ins 9.01 (15); "~~utilization management requirement, including a preauthorization requirement, is a referral if the utilization management provision is applied in a discriminatory manner so as to favor participating providers~~" in s. Ins 9.01 (15); and "~~2006~~" in both s. Ins 9.40 (6) and (7). Section Ins 9.07 (1) should be reviewed for similar problems.

g. In the first sentence of s. Ins 9.01 (15), the comma following "Stats.", and the word "and" should also be shown as underlined as they are being inserted. [See s. 1.06 , Manual.]

h. In s. Ins 9.01 (15), the definition of "preferred provider plan" is being amplified beyond its meaning in s. 609.01 (4), Stats., with substantive provisions being included as to the consequences that will apply if a preferred provider plan takes certain actions. Substantive provisions cannot be incorporated as part of a definition. [s. 1.01 (7) (b), Manual.]

i. SECTION 10 should simply indicate that s. Ins 9.30 is repealed. The language should not be included as over-stricken. [s. 1.06 (1), Manual.]

j. If the treatment clause indicates that a provision is being amended, all of that provision should be shown, even the portions that are not being changed. Alternatively, the treatment clause may refer only to those provisions that are being amended.

For example, in SECTION 11, the treatment clause could indicate that "9.31 and 9.32 are renumbered 9.30 and 9.31 and, as renumbered, s. 9.30 (intro.) and 9.31 (1) (intro.) and (2) (intro.), (a), and (d) are amended to read:". Otherwise, all of these two sections should be shown, even the parts that are not changed. (As noted above, it is not necessary to renumber these provisions.)

Similarly, SECTION 14 indicates that s. Ins 9.37 is being amended, but only parts of s. 9.37 are produced in the proposed order. (In particular, most of s. 9.37 (1) is not reproduced.)

k. In ss. Ins 9.32 and 9.33, the titles to the sections should be shown with an initial capital letter and in bold print. [s. 1.05 (2) (b), Manual.]

l. In ss. Ins 9.325 and 9.34, titles to the sections should be included. [s. 1.05 (1), Manual.]

m. In s. Ins 9.325, the two references to "Stat." should be changed to "Stats."

n. Section Ins 9.33 should not create sub. (1) inasmuch as there are no other subsections. [s. 1.03 (intro.), Manual.] It appears that sub. (1) (a) should be sub. (1) and that sub. (1) (b) should be sub. (2). (Further, the title to sub. (1) is shown in the incorrect type style.) [s. 1.05 (2) (c), Manual.]

o. The note in s. Ins 9.33 referring to the forms should indicate that the forms can be obtained at no charge. Also, if the forms are available on the Internet, the note should indicate the website. [s. 1.09 (2), Manual.]

p. In ss. Ins 9.32 (1) (a) 1., (b) 1., (c) 1., and (d) 1., and 9.34 (1) (e) 1. should end with a period, rather than a semicolon or the word "or." [s. 1.03 (intro.), Manual.]

q. In s. Ins 9.34 (2), the structure of par. (f) is not consistent with the new structure of the remaining paragraphs. A new subsection should be created.

r. In SECTION 17, the language in s. Ins 9.40 (1) (intro.) [(1) In this section:] should not be included as it is not affected. Also, s. Ins 9.40 (1) (c) should be repealed in a separate section.

s. In s. Ins 9.42 (1), "organizations" is shown as both underscored and over-stricken. It should be shown as over-stricken. Also, it should be changed to "~~organization~~" as that is the term used in the current rule that is being removed. [s. 1.06 (1), Manual.]

t. In s. Ins 9.42 (4) (intro.), "shall:" should be changed to "shall do all of the following:" to make the relationship of the subsequent paragraphs clear. [s. 1.03 (8), Manual.]

u. The treatment clause in SECTION 21 should specify that it is Appendix D to ch. Ins 9. Also, in the Appendix, it is not necessary to include the word "(title.)."

4. Adequacy of References to Related Statutes, Rules and Forms

a. In Item 3. of the Analysis, the notation "s." should be replaced by the notation "ss."

b. In the treatment clause in SECTION 1, the reference to "3.67 (1) (a) and (d) are amended" should be changed to "3.67 (1) (a) and (c) are amended."

c. Section Ins 9.32 (1) (d) provides an exception to the requirements in s. Ins 9.32 (1) (b) and (c). Thus, s. Ins 9.32 (1) (b) and (c) should include qualifying language such as: "Except as provided in par. (d), ..."

d. Section Ins 9.32 (2) specifies that an insurer offering a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when performed by a participating provider is subject to the requirements of several statutes, namely, ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), Stats., and also the requirements of s. Ins 9.34 (1) (a) and (2) (a). (In the cross-reference, the word "and" should be inserted before "9.40" and the notation "s." should be replaced by the notation "ss.")

It would be useful to include cross-references to other provisions in ch. Ins 9 that must be complied with that interpret ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), Stats., which appear to include ss. Ins 9.34 (1) (b) and (c), 9.37 (4), and 9.40 (2). Also, should s. Ins 9.34 (2) (a) be included as a requirement if s. Ins 9.34 (1) (a) is cited as a cross-reference in s. Ins. 9.32 (2).

e. Section Ins 9.33 (1) (a) refers to certifying compliance with the access standards "of this section." However, no access standards are specified in s. Ins 9.33. The correct reference should be substituted.

Also, s. Ins 9.33 (1) (a) requires certification, from a defined network plan that is not a preferred provider plan, of compliance with s. 609.22, Stats., and with "s. Ins 9.34, if applicable." It appears that s. Ins 9.34 (1) will always be applicable; thus, this more specific cross-reference should be provided, and the phrase "if applicable" should be deleted.

f. Section Ins 9.33 (1) (b) requires certification, from a defined network plan offering a preferred provider plan, of compliance with specified subsections of s. 609.22, Stats., and with s. Ins 9.34 "if applicable." It appears that s. Ins 9.34 (2) will be applicable; thus, the reference to "if applicable" is confusing. It also appears that, under s. 609.35, Stats., the remaining subsections of s. 609.22, Stats., and s. Ins 9.34 (1) will also be applicable if the preferred provider plan does not cover the same services when performed by a nonparticipating provider that it covers when performed by a participating provider. This should be made clearer, for example, by requiring certification of compliance with these provisions also (for example, by cross-referencing the requirements in s. Ins 9.32 (2)).

g. Finally in s. Ins 9.33 (1) (b), "ss." should be changed to "s." since only one section is cited.

h. In s. Ins 9.34 (2) (e) 1. and 2., the notation "sub." should be replaced by the notation "par."

i. Section Ins 9.38 (4) (c) refers to "subsection 9.34 (2) (a) 4." The cross-reference is incorrect as there is no such provision. (If there were, the correct format would be to refer to "s. Ins 9.34 (2) (a) 4.") [See s. 1.07 (2), Manual.]

5. Clarity, Grammar, Punctuation and Use of Plain Language

a. The third paragraph of Item 5. of the Analysis indicates that if a preferred provider plan engages in certain behaviors, the preferred provider plan will be treated by the Commissioner of Insurance (Commissioner) as a defined network plan and be subject to all requirements of a defined network plan. Also, the fourth paragraph describes the differences between regulation of defined network plans and preferred provider plans, for example, implying that all defined network plans must comply with the items specified. However, most of the items specified apply to only a subset of defined network plans, that is, those that are not preferred provider plans and those that are preferred provider plans but do not cover the same services when performed by a nonparticipating provider that are covered when performed by a participating provider.

It is confusing to indicate that such a preferred provider plan will be treated as a defined network plan because, under the statutory definitions, most (but not all) preferred provider plans are defined network plans. It would appear to be more useful to explain that the statutes: (1) impose certain requirements on all defined network plans; (2) impose other requirements on

defined network plans that are not preferred provider plans (see ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), Stats.); and (3) under s. 609.35, Stats, also impose the requirements listed in item (2) on preferred provider plans that do not cover the same services when performed by a nonparticipating provider that are covered when performed by a participating provider.

A similar comment applies to s. Ins 9.01 (15), defining "preferred provider plan" and indicating that a preferred provider plan that takes certain actions "is subject to all requirements of a defined network plans[sic]." A similar comment applies to s. Ins 9.32 (2) (intro.), which indicates that an insurer offering a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when performed by a nonparticipating provider "is subject to the requirements of a defined network plan...." Again, these provisions do not appropriately distinguish between the types of defined network plans.

b. In the last sentence of the second paragraph of Item 5. of the Analysis, the word "meeting" should be replaced by the word "meetings."

c. In the second sentence of the sixth paragraph of Item 5. of the Analysis, the word "to" should be inserted after the word "compared."

d. In the last sentence of the ninth paragraph of Item 5. of the Analysis, "insurer comply" should be changed to "insurer complies" and the last comma should be replaced by the word "and."

e. In the first sentence of the 10th paragraph of Item 5. of the Analysis, "non-emergent" should be changed to "non-emergency."

f. In the second sentence of the 13th paragraph of Item 5. of the Analysis, the word "hour's" should be replaced by the word "hours." In the last sentence of this paragraph, commas should be inserted after the words "operation" and "appointments."

g. In the last sentence of the last paragraph of Item 5. of the Analysis, "amply time" should be changed to "ample time."

h. In the first paragraph of the Illinois comparison in Item 7. of the Analysis, "requires health care plan" should be changed to "requires a health care plan."

i. In the first sentence of the second paragraph of the Illinois comparison in Item 7. of the Analysis, "are" should be changed to "is."

j. In the first sentence of the fourth paragraph of the Illinois comparison in Item 7. of the Analysis, "requires health" should be changed to "requires that health."

k. The last sentence of the second paragraph of the Minnesota comparison in Item 7. of the Analysis, should be changed to make it grammatically correct.

l. In the first sentence of the first paragraph of the Michigan comparison in Item 7. of the Analysis, "requires . . . shall provide" should be changed to "requires . . . to provide." Also, "services provide" should be changed to "services provided."

m. In the first sentence of the last paragraph of Item 8. of the Analysis, "In addition the complaint review" should be changed to "In addition to the complaint review." Also, in the fourth sentence, the word "representative" should be replaced by the word "representatives."

n. In the first paragraph of Item 9. of the Analysis, it would be useful to explain that the Commissioner has authorized one LSHO to write up to 10% of its premium as a preferred provider plan. This could be done by changing the phrase "and authorized to only write 10%" to "that has been authorized by the Commissioner to write up to 10%." In the last sentence of the last paragraph of Item 9., the word "affect" should be replaced by the word "effect."

o. In the last sentence of the first paragraph of Item 11. of the Analysis, "stated in above" should be changed to "stated above."

p. In s. Ins 9.01 (3), "to the insurer" should be changed to "to an insurer." Also, "about an insurer" should be changed to "about the insurer."

q. In s. Ins 9.01 (6), a comma should be inserted after the word "plan."

r. Should the definition of "intermediate entity" in s. Ins 9.01 (9m) also refer to enrollees of a preferred provider plan in order to acknowledge the subset of preferred provider plans that are not defined network plans? Also, should LSHOs be included to apply to those that cover services other than dental or vision? Finally, the word "a" should be inserted before the third occurrence of the word "provider."

s. In s. Ins 9.01 (10m), it appears that "limited scope plan" should be defined as a plan offered by an insurer that provides certain benefits, rather than referring to the plan as the insurer.

t. In s. Ins 9.01 (15), the definition of "preferred provider plan" is being amplified beyond its meaning in s. 609.01 (4), Stats., including the statement that if a preferred provider plan uses utilization management for denying access to coverage of the services of nonparticipating providers without "just cause" and with "such frequency as to indicate a general business practice," the Commissioner will treat the plan as a defined network plan subject to all requirements of a defined network plan.

As noted above, such substance cannot be included in a definition. Moreover, the rule does not specify how, on what basis, and by whom a determination is made that there is not "just cause" or when there is "such frequency as to indicate a general business practice" in order to trigger this consequence.

Also, the last word in the definition should be "plan," not "plans."

u. In s. Ins 9.07 (1), the first occurrence of the word "a" should be deleted.

v. The rule is inconsistent by sometimes referring to insurers (or an insurer) offering defined network plans and sometimes referring to insurers (or an insurer) offering a defined network plan. See, for example, ss. Ins 9.30 (intro.), 9.31 (2) (intro.), 9.36, 9.37, and 9.38 (intro.) and (4) (intro.) and (c). If the provisions are intended to apply regardless of whether an

insurer offers only one defined network plan or offers one or more defined network plans, ch. Ins 9 should consistently refer to insurers (or an insurer) offering a defined network plan.

Also, in the first sentence of s. Ins 9.32 (1) (d) (intro.), "a preferred provider plans" should be changed to "a preferred provider plan" or "preferred provider plans."

w. In s. Ins 9.31 (2), the word "and" should be inserted before the notation "ss."

x. In s. 9.32 (1) (a) (intro.), a period should be inserted following "Stats."

y. Section 609.35, Stats., provides that 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 certain requirements that are otherwise imposed only on defined network plans that are not preferred provider plans. Section Ins 9.32 (1) provides that, for purposes of s. 609.35, Stats., a preferred provider plan is considered to be covering the same services when performed by a nonparticipating provider as when performed by a participating provider (and, thus, may avoid being subjected to the requirements specified in ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), Stats.) only if the insurer complies with one of two conditions specified in s. Ins 9.32 (1) (a) 1. and 2., which relate to the coinsurance rate.

In contrast, the provisions in s. Ins 9.32 (1) (b) (relating to coinsurance differentials between participating and nonparticipating providers) and in s. Ins 9.32 (1) (c) (relating to deductible differentials between participating and nonparticipating providers) are written as express requirements placed on preferred provider plans that have no express connection to the concept of covering the same services for purposes of s. 609.35, Stats. The following comments apply:

1) A plain language reading of the statutes suggests that "cover[ing]" the same services" relates to the concept of comparing how participating and nonparticipating providers are dealt with by the insurer. This does not occur in s. Ins 9.32 (1) (a), but does occur in both s. Ins 9.32 (1) (b) and (c). However, it is only s. Ins 9.32 (1) (a) that is specified as providing the test for covering the same services.

2) Section Ins 9.32 (1) (b) and (c) are requirements placed on preferred provider plans. It would be useful to more clearly specify the consequences if there is not compliance. (For example, for noncompliance with s. Ins 9.32 (1) (a), the consequences are specified in s. Ins 9.32 (2).)

3) Because some plans have copayments for certain services, rather than coinsurance, is a significant differential in copayments between participating and nonparticipating providers considered to be covering the same services?

4) The proposed definition of "preferred provider plan" in s. Ins 9.01 (15) indicates that if the insurer offering the preferred provider plan engages in certain behaviors relating to access to care by a nonparticipating provider, the preferred

provider plan will be subject to all requirements of a defined network plan. It appears that these behaviors relate to the concept of "covering the same services." If so, it is not clear why they are not included in s. Ins 9.32 (1).

z. Section Ins 9.32 (1) (b) (intro.) and (c) (intro.) both require an insurer to "***do*** either of the following." [Emphasis added.] Thus, s. Ins 9.32 (1) (b) 1. and 2. and (c) 1. and 2. should both describe some action to be taken. However, neither do. Either the introductory language should be changed to refer to offering plans that have one of those characteristics or the action to be taken should be included in the subdivisions.

aa. Section Ins 9.32 (1) (a) 2. refers to providing the enrollee with "the disclosure notice in sub. (3)." In contrast, s. 9.32 (1) (b) 2. and (c) 2. refer to providing the enrollee with "a disclosure notice that is compliant with sub. (3)." Was a difference intended? If not, ambiguity would be decreased by selecting one phrase and using it consistently.

bb. In the first sentence of s. Ins 9.32 (1) (d) (intro.), it appears that the conjunction "or" preceding "conditions" should be changed to "and."

cc. Section Ins 9.32 (1) (d) permits an insurer to make exceptions to coinsurance and deductible differentials in s. Ins 9.32 (1) (b) or (c) to the extent "reasonably necessary" to encourage enrollees to use "participating providers or centers of excellence for transplant or other unique disease treatment services, preventive health care services limited to immunizations pursuant to s. 632.895 (14), Stats., and services as covered benefits greater than minimum required for specific mandated benefits under ss. 632.895 and 632.89, Stats." when the insurer makes certain disclosures. The following comments apply:

1) The rule does not explain how, on what basis, and by whom it is determined whether, and to what extent, exceeding the differentials is "reasonably necessary."

2) It is not clear why the phrase "preventive health services limited to" is necessary. It appears that reference to "immunizations pursuant to s. 632.895 (14), Stats.," would be sufficient.

3) "Than minimum" should be changed to "than the minimum."

4) "s. 632.895 and 632.89" should be changed to "ss. 632.895 and 632.89."

dd. In s. Ins 9.32 (1) (d) 1., "benefits are" should be changed to "benefits that are."

ee. In s. Ins 9.32 (1) (d) 2., "covered when" should be changed to "covered only when." Also, "disparity in than" should be changed to "disparity than."

ff. Section Ins 9.32 (1) (e) is a partial sentence. Since there is no s. Ins 9.32 (1) (intro.) providing introductory language, this paragraph should be revised to be a free-standing complete sentence.

gg. In s. Ins 9.32 (3), it is noted that the disclosure must be provided at the time of solicitation and in the certificate of coverage under a group policy and in an individual policy. In

contrast, a different notice referred to in s. Ins 9.32 (1) (d) must be provided at the point of sale and within the policy. Should s. Ins 9.32 (1) (d) refer to a certificate under a group policy? Also, was the distinction between time of solicitation and time of sale intended?

hh. Section Ins 9.32 (3) includes the text of a notice to be provided about limited benefits that will be paid when nonparticipating providers are used. It makes no mention that the terms specified in the notice do not apply in emergency situations, even though s. Ins 9.34 (1) (d) provides that that is the case. It appears that the notice should comment on this to be consistent with s. Ins 9.34 (1) (d).

ii. In the highlighted sentence in the notice under s. Ins 9.32 (3), "COINSURNACE" is misspelled. Also, in that notice, the references to "members" and "member" are confusing; it appears that the references should be changed to the defined term "enrollee."

jj. Sections Ins 9.32 (4) and 9.33 (1) (a) and (b) refer to an "insurer." They also refer to the "company." If these are one and the same, a consistent term should be used to avoid ambiguity.

kk. Section Ins 9.33 (1) (b) requires insurers offering a preferred provider plan to file a certification within three months after the effective date of that section, with the Revisor of Statutes to insert the date. SECTION 23 provides an effective date of the first day of the first month following publication. However, SECTION 24 provides that the rule first applies to newly issued policies on January 1, 2007 and to renewing policies on January 1, 2008. What is the purpose and effect of the delayed applicability date? Which provisions of the rule are affected by the applicability date?

ll. In the last sentence of s. Ins 9.34 (1) (d) and in s. Ins 9.34 (2) (e) (intro.), (f), and (g), it may be useful to specifically refer to coinsurance as that term is prominently used in other parts of ch. Ins 9.

mm. In s. Ins 9.34 (2) (b), it appears that "that" should be changed to "to."

nn. In s. Ins 9.34 (2) (c) and (e), "non-emergent" should be changed to "non-emergency."

oo. Section Ins 9.37 (4) does not make clear how, on what basis, and by whom, a determination is made that there is not "just cause" or that there is "such frequency as to indicate a general business practice."

pp. Section Ins 9.40 (2) (a) and (b) are inconsistent. Section Ins 9.40 (2) (a) imposes certain requirements, as of April 1, 2000, on insurers with respect to a defined network plan that is not a preferred provider plan. Section Ins 9.40 (2) (b) indicates that insurers offering defined network plans that are not preferred provider plans or health maintenance organizations must comply with s. Ins 9.40 (2) (a) by April 1, 2007. However, the plans in s. Ins 9.40 (2) (b) are a subset of those described in s. Ins 9.40 (2) (a), which creates an inconsistency between the provisions. It appears that s. Ins 9.40 (2) (a) would have to include the phrase "except as provided in par. (b)" to remedy this inconsistency.

qq. Section Ins 9.40 (2) (b), (6), and (7) impose certain requirements on insurers offering defined network plans that are not preferred provider plans or health maintenance organization plans. In the case of s. Ins 9.40 (2) (b), they are required to begin annually submitting a quality assurance plan April 1, 2007; in the case of s. Ins 9.40 (6), they are to begin annually submitting standardized data sets by June 1, 2008; and in the case of s. Ins 9.40 (7), they are required to include certain information about quality assurance plans in materials by April 1, 2008.

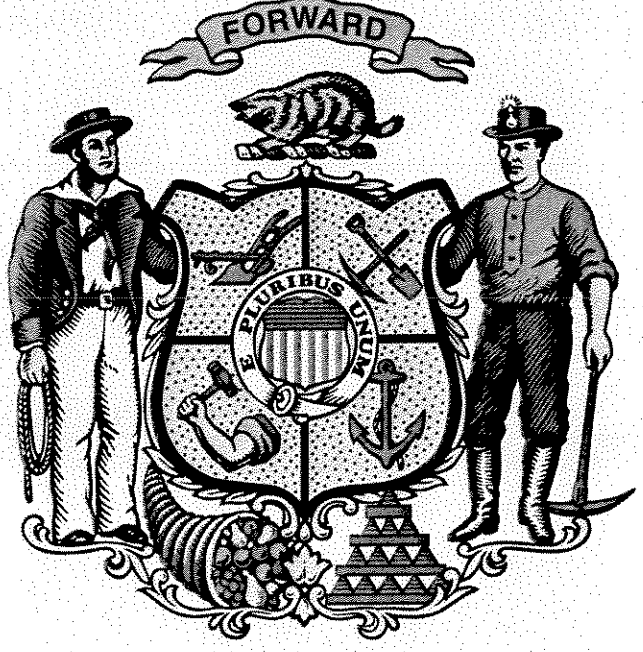
The Analysis does not explain that such plans are uniquely affected by the rule. It would be helpful if the Analysis explained the type of entity included in this category and describe the special provisions applicable to them.

rr. In the next-to-last sentence of s. Ins 9.42 (1), it appears that "network and limited" should be changed to "network or limited" to be consistent with the first sentence in that subsection.

ss. Section Ins 9.42 (9) indicates that an insurer offering a preferred provider plan that is not a defined network plan must comply with s. Ins 9.42 "to the extent applicable." This does not provide sufficient information to determine which other provisions are applicable. To the extent those other provisions make clear that they are applicable, s. Ins 9.42 (9) is not needed.

tt. In SECTION 22, the comma should be deleted in the treatment clause.

uu. In s. Ins 18.03 (2) (c) 1., a space should be inserted between "in" and "s."


FORWARD
E PLURIBUS UNUM

Clearinghouse Rule 05-059

JOINT ASSEMBLY INSURANCE AND SENATE AGRICULTURE AND INSURANCE COMMITTEE HEARING

TESTIMONY OF JORGE GOMEZ
WISCONSIN COMMISSIONER OF INSURANCE

OCTOBER 13, 2005

Managed Care vs. Defined Network

- Background
  - Prior to 2001 Wis Act 16, Preferred Provider Plans and Managed Care Plans were separately regulated under state statutes and rules.
  - 2001 Wisconsin Act 16 renamed managed care plans as defined network plans and added a requirement that OCI recognize the difference between preferred provider plans and other types of defined network plans in its rules.

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Rulemaking Process

- OCI submitted proposed rules to the Legislature in 2002 to implement Act 16 changes under then-Commissioner O'Connell
- Extensive negotiation among OCI, both Legislative committees and affected insurers
- Rule was withdrawn December 2002

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Rulemaking Process

- Many preliminary discussions about INS 9 occurred between February 2003 and July 2004 during OCI Life and Disability Council Meetings and in informal presentations to industry and interest groups
- In July 2004, Commissioner Gomez held a public hearing to discuss insurer and consumer issues related to PPO coverage in the current market.
- OCI issued a Notice of Scope in September 2004.
- Commissioner Gomez chaired four public working meetings to openly discuss the proposed rule in an effort to achieve a workable regulation between November 2004 and May 2005.

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Rulemaking Process

- Discussions included:
  - Statutory direction of the Legislature
  - Effects on consumers through review of complaints and common misunderstanding of health insurance products
  - Effects on employers
  - Effects on providers and insurers
  - Effects of a changing marketplace

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Rulemaking Process

- Public Working meeting participants:
  - Wisconsin Association of Life and Health Insurers
  - Council for Affordable Health Insurance
  - Wisconsin Association of Provider Networks
  - Representatives from 7 domestic and non-domestic health insurers

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Legislative Direction

- Commissioner permitted to promulgate rules relating to PPPs and defined network plans that:
  - Ensure that enrollees are not forced to travel excessive distances to receive health care services
  - Ensure that the continuity of patient care for enrollees meets the requirements of s. 609.24, Stats.
- Commissioner required when promulgating rules:
  - To recognize the differences between preferred provider plans and defined network plans
  - To take into account the fact preferred provider plans provide coverage for services of nonparticipating providers

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health Access to health Care

Reasons for Revision to Ins 9

- Insured was diagnosed w/emergency appendectomy. Insured "had no choice…and no time to seek services 'in-network'." Bill from the hospital; $5,000.
- "We did not realize that even though his chemo & radiation was through the same medical building at Wausau, WI (At the desk, go right for chemo & go left for radiation), that the chemo was in network & the radiation was out of network."
- Insured had tests done at a preferred provider hospital. However, the radiologist affiliated with the hospital was not a PPO provider. She was subject to a $500 deductible and 30% co-payment, instead of no deductible and 100% coverage.

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Reasons for Revision to Ins 9

- Insured was transported from local community hospital to Green Bay hospital because family thought it was a PPO provider and it was a cardiac care hospital. When the EOBs came they were shocked as the Green Bay hospital is listed in their provider directory. They were unaware providers could drop out on a yearly basis. They were under the impression all providers in their directory would stay the same for the length of the contact since they never received an updated directory.
- Insured delivered by c-section and received billing from non-network neonatal specialist. She was informed it was hospital policy to have a neonatal specialist present at all c-sections. She was also informed there were no in-plan neonatal specialist in Green Bay. Insured states that she is "not responsible for contracting doctors to join the network, nor am I capable of changing hospital policy. I was at my in-plan hospital, where my in-plan provider delivered my baby. I also had an in-plan pediatrician on file. I did everything necessary to stay in-plan".

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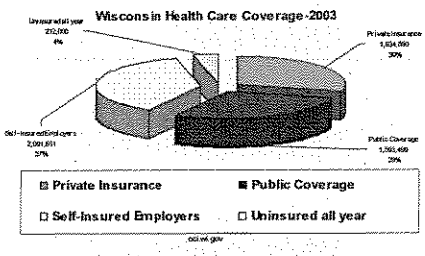
Health Insurance Marketplace

- Fractured Marketplace



Health Insurance Marketplace

- HMO enrollment declined 25% since 1996
- PPO enrollment increased 21% since 1996
- Public health coverage increased 33% from 2001 to 2002

Source: OCI Health Insurance Coverage 2003

Health Insurance Access Issues

OCI Complaint Survey Results

- OCI conducted a survey of complaints between January 1, 2003 through May 31, 2004. The results identified 936 PPO complaints:
  - Claim Administration (83%)
  - Underwriting (9%)
  - Policyholder service (5%)
  - Marketing (2%)
  - Other (1%)
- 33 complaints involved ancillary providers
- 15 complaints involved emergency services that were subject to nonparticipating provider deductibles and co-payments
- 19 complaints involved changes in the provider networks
- 18 complaints involved enrollee's lack of understanding PPP requirements
- 71 complaints within the "other" category included UCR determinations, pre-certification and preauthorization issues.

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PPO Plan Costs on the Typical Consumer

	Plan 1	Plan 2
PPP Plan with $500 and $5000 deductible	$500 Ded	$5000 Ded
Gross Income	$44,503.00	$44,503.00
Net Income after taxes	31,419.12	31,419.12
Less Housing	13,887.00	13,887.00
Net Income less housing	17,532.12	17,532.12
Premiums and deductibles	7,251.35	7,942.24
Net annual living expenses	**10,280.77**	**9,589.88**

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Rulemaking Process

- The goals were met:
  - The process was open
  - The process was inclusive
  - All sides made significant compromises
  - Not everyone got what they wanted
  - At the end of the day reasonable people came to a reasonable, workable solution.
  - Consumers receive more information to make better informed decisions

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Rule Highlights

- Rule outlines what is a Preferred Provider Plan (PPP)
  - cannot require referrals for coverage
  - must provide the same coverage regardless of whether the services are provided by participating or nonparticipating providers
  - must provide coverage with the insurer paying at a coinsurance rate of not less than 60% or not less than 50% with a required disclosure

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Rule Highlights

- Quality Assurance
  - PPPs must develop Remedial Action Plans when quality problems are identified about participating primary care providers
  - Less stringent requirement than Quality Assurance Plan requirement for Defined Network Plans
- Enrollee Notification
  - Defined Network plans must notify affected enrollees upon termination of providers from plan
  - PPPs may contract this requirement to another entity or to providers to notify enrollees

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Rule Highlights

- Reporting
  - PPPs not required to report HEDIS data
  - Defined Network Plans must report HEDIS data
- Access Standards
  - Defined Network plans and PPPs must annually certify compliance with applicable access standards
    - Promptness, geographic location, hours of operation, waiting times for appointments, and after hours care
    - Must reflect the usual practice in the local area
    - Does not dictate provider hours of operation

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Rule Highlights

- Provider adequacy
  - Required to have sufficient number and type of providers to adequately deliver all covered services
  - PPP is not required to offer a choice of providers, but must have at least one primary care provider and one OB/GYN provider that is accepting patients.
  - Defined Network plans must comply with all access standards

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Rule Highlights

- Cost Sharing
  - Achieves proper balance between steering of enrollees and imposing financial penalties for use on nonparticipating providers
  - Not less than 60% coinsurance for insurer-40% coinsurance for enrollee or;
  - 50/50 coinsurance if a written disclosure of limited coverage is provided to enrollee by the insurer.

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Rule Highlights

- Cost Sharing (cont'd)
  - Differences between in and out of network coinsurance percentage cannot be greater than 30% without written disclosure to the enrollee
  - Differences between in and out of network deductibles cannot be greater than two times greater or no more than $2,000 without written disclosure to the enrollee

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Rule Highlights

- Cost Sharing (cont'd)
  - Differences between in and out of network co-payments cannot be greater than three times greater or no more than $100 for services provided by a health care provider or $300 services provided by a health care facility for without written disclosure to the enrollee

Rule Highlights

- Exclusions
  - PPPs must apply material exclusions equally between participating and non-participating providers
  - Cannot use exclusions to steer enrollees to participating providers
- Ancillary Providers
  - PPPs must include in participating provider contracts a requirement that at the time of scheduling elective procedures the provider must disclose to the enrollee all providers that may participate in procedure and whether each provider is a participating or non-participating provider
  - PPPs must inform enrollees of the financial implications of using non-participating providers

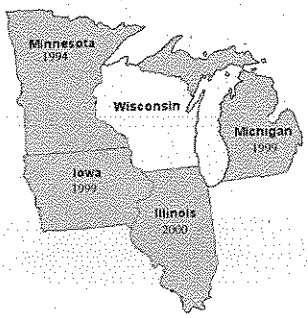
Rule Highlights

- Emergency Medical Care
  - Prudent layperson mandate
  - Defined Network Plans and PPPs that provide ER care as a covered benefit must provide coverage as though the provider was a participating provider when enrollee cannot reasonably reach a preferred provider or is admitted for inpatient care by a non participating provider
  - Plans must reimburse at non-participating provider rate and apply cost sharing at participating provider rate

INS 9-Major Provisions

- Regulation in keeping with Legislative intent
- Adequate access to providers
- Emergency medical care coverage
- Additional information to assist consumers in making informed decisions regarding health care including financial implications

Regulation in the Midwest



QUESTIONS OR COMMENTS?