WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06

(session year)

Senate

(Assembly, Senate or Joint)

Committee on Agriculture and Insurance (SC-AI)

File Naming Example:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

Published Documents

- *Committee Hearings* ... *CH* *(Public Hearing Announcements)*
- **

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

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

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

Information Collected For Or Against Proposal

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

- *Clearinghouse Rules* ... *CRule*

05hr_CRule_05-059_SC-AI_pt04

- *Hearing Records* ... *HR* *(bills and resolutions)*
- **

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

TO: JOHN PERLICH, OFFICE OF SENATOR KAPANKE
JOYCE KIEL, AND
RICHARD SWEET, LEGISLATIVE COUNCIL STARR

From: Adam Peer, Chief Policy Advisor

Date: November 11, 2005

RE: Materials for Drafting Healthcare Bill

Please find attached the following documents for your information as we discuss drafting a healthcare bill.

ASP

State Capitol, Room 8 North, PO Box 8953, Madison, WI 53705-8953
Capitol: 608-266-8580, Fax 608-282-3697

TO: REPRESENTATIVE ANN NISCHKE

From: Adam S. Peer, Chief Policy Advisor

Date: October 26, 2005

RE: Proposed Healthcare Reform Act of 2005

Background

As you know, the Speaker has referred Clearinghouse Rule 05-059 to the Insurance Committee for its review and comment period as well as the Assembly's first opportunity to request changes from the agency or object to the rule's promulgation.

Aside from grammatical and technical changes, Legislative Council to the committee has reviewed the rule and found areas where one could argue the agency has gone beyond its statutory authority and made policy decisions that should be made by lawmakers, not administrators.

Additionally, the structure of rule, especially the use of definitions, one could argue is troublesome, because it makes policy decisions that should be made explicit elsewhere.

Interested parties and stakeholders, during a public hearing on the rule, have brought forth other concerns and problems with what this rule proposes to do.

As you know, under the administrative rules process, the rule is the agency's, the Legislature review it, but in a greater degree the pace is set by the willingness of the agency to consider the Legislature's requests.

Proposal

Given these circumstances, I would suggest that one consider introducing a bill that does all of the following: Sub Chp III

1. Implements the advisable part of the rule, but are parts that would either be better set forth in statute or parts the agency lacks authority to promulgate in the first place.
2. Write the bill with greater detail on the Legislative intent of the original legislation that created this part of the statutes.
3. To a greater extent, better define the scope of statutory authority of the agency to promulgate rules in this area.

Discussion

Taken as a whole, there are very good parts to this rule that make good public policy, for example, the explicit guarantee to emergency medical services. It is advisable public policy. However, it is not advisable to allow an agency to promulgate this by rule, when this is a power reserved for the Legislature.

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Lawmakers as well as the Governor would also find it advantageous to enact good public policy, that would also have wide public support, as a bill rather than an administrative rule that would probably obtain little public attention.

By moving the discussion from a rule to a bill, legislators would have better control over the intent and outcome rather than to depend on the agency's willingness to work with lawmakers.

<u>Conclusion</u>
In the end, it is my belief better public policy would emerge from a legislative process over an administrative rules process in this particular situation. This issues is well studied and written about given its history, so drafting instructions and a subsequent bill would not be difficult to compose.

With the right communications plan, this bill would have excellent chances for bipartisan support as well as a perceived win for Majority and Minority Members as well as the Governor.

If you have any questions, please feel free to contact me.

ASP

Attachments

State Capitol, Room 8 North, PO Box 8953, Madison, WI 53705-8953
Capitol: 608-266-8580, Fax 608-282-3697

WISCONSIN LEGISLATIVE COUNCIL

Terry C. Anderson, Director
Laura D. Rose, Deputy Director

TO: MEMBERS OF THE ASSEMBLY COMMITTEE ON INSURANCE AND THE SENATE COMMITTEE ON AGRICULTURE AND INSURANCE

FROM: Joyce L. Kiel, Senior Staff Attorney

RE: Clearinghouse Rule 05-59, Relating to Revising Requirements for Insurers Offering Defined Network Plans, Preferred Provider Plans, and Limited Service Health Organizations in Order to Comply With Recent Changes in State Laws

DATE: October 12, 2005

This memorandum relates to Clearinghouse Rule 05-59 (CR 05-59), relating to revising requirements for insurers offering defined network plans, preferred provider plans (PPPs), and limited service health organizations (LSHOs) in order to comply with recent changes in state laws. The memorandum does the following:

- Describes the procedural background of CR 05-59.
- Provides general background information about: defined network plans, health maintenance organizations (HMOs), PPPs, and LSHOs; statutes affecting them that relate to this proposed rule; and the authority of the Office of the Commissioner of Insurance (OCI) to promulgate rules relating to insurers offering such plans.
- Describes the provisions of CR 05-59.
- Lists my comments about CR 05-59.
- Describes options available to the committees.

PROCEDURAL BACKGROUND

OCI submitted CR 05-59 in response to 2001 Wisconsin Act 16, which, in pertinent part, eliminated the use of the term "managed care plan" and substituted the term "defined network plan" and made various changes to ch. 609, Stats., which now relates to defined network plans.

Following OCI's submission of CR 05-59 to the Legislature, the rule was referred to the Assembly Committee on Insurance on September 7, 2005, and the Senate Committee on Agriculture and Insurance on August 31, 2005. On October 6, 2005, notice was posted of a hearing of the Assembly Committee, which extends the Assembly Committee's jurisdiction until November 7, 2005, unless an intervening event occurs. On September 30, Senator Kapanke, Chair of the Senate Committee, wrote to OCI requesting a meeting, which has the effect of extending the Senate Committee's jurisdiction until October 31, 2005, unless an intervening event occurs. The committees have now scheduled a joint hearing on October 13, 2005, with a possible executive session by either or both committees following the hearing.

General Background

Currently, ch. Ins 9, Wis. Adm. Code, relates to managed care plans. Subsequent to the passage of 2001 Wisconsin Act 16, OCI submitted Clearinghouse Rule 02-69 (CR 02-69) to propose amendments to ch. Ins 9, Wis. Adm. Code, to refer to defined network plans, rather than managed care plans, and to implement the changes made by Act 16. The chairs of both of the committees to which CR 02-69 was referred (the Assembly Committee on Health and the Senate Committee on Insurance, Tourism, and Transportation) requested a meeting with OCI. OCI then submitted several modifications to CR 02-69.

However, OCI eventually withdrew CR 02-69 without ever promulgating it. In 2004, OCI attempted to proceed with CR 02-69 but discontinued the initiative after the Legislative Council Clearinghouse indicated that there was no statutory process for resubmitting a withdrawn rule to the Legislature.

OCI has now submitted CR 05-59 to change references in the Administrative Code from managed care plan to defined network plan and to implement the changes made by Act 16.

Definitions of Types of Plans

CR 05-59 relates to several types of plans offered by insurers: defined network plan, HMO, PPP, and LSHO. Each type of plan is defined in the statutes. [See s. 609.01 (1b), (2), (4), and (3), Stats., respectively.) The matter may be somewhat confusing as some of the types of plans include part, but not all, of another type of plan. For example, most, but not all, PPPs are a defined network plan.

The most significant features of the pertinent statutory definitions are as follows:

1. Defined network plan—s. 609.01 (1b), Stats. Significant features include:

    a. Is a "health ***benefit*** plan," as defined in s. 609.01 (1g), Stats. (Any hospital or medical policy or certificate, but ***excluding*** certain coverage when provided under a separate policy, certificate, or contract, such as limited-scope dental or vision benefits, or benefits for nursing home care, health care, community-based care, or any combination of these.)

b. Requires or creates incentives for enrollees to use certain health care providers that are managed, owned, under contract with, or employed by the insurer (collectively referred to as participating providers).

2. HMO—s. 609.01 (2), Stats. Significant features include:

   a. Is a "health ***care*** plan," as defined in s. 609.01 (1m), Stats. (Any insurance contract covering health care expenses.)[1]

   b. Provides ***comprehensive*** health care services.

   c. Coverage for services performed by ***participating*** providers.

   d. Consideration provided to participating providers is predetermined periodic fixed payments (commonly referred to as capitated payment).

3. PPP—s. 609.01 (4), Stats. Significant features include:

   a. Is a "health ***care*** plan."

   b. Coverage can be ***comprehensive*** health care services ***or limited*** range of health care services (for example, dental or vision coverage under a separate policy).

   c. Coverage ***regardless*** of whether the services are performed by a ***participating or nonparticipating provider***. (PPPs typically create incentives (usually in the form of higher benefits) for an enrollee to receive services from a participating provider. Unless a PPP is providing limited services in a separate policy, this means the PPP comes under the definition of a defined network plan.)

   d. Consideration provided to participating providers is ***not*** capitated. (As a matter of practice, a participating provider may have agreed to charge less than the provider's standard fee-for-service rate for a service rendered to a PPP enrollee.)

   e. Services must be available ***without referral***.

4. LSHO—s. 609.01 (3), Stats. Significant features include:

   a. Is a "health ***care*** plan."

   b. Provides ***limited*** health care services.

   c. Coverage for services performed by ***participating*** providers.

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[1] This definition is broader than a "health benefit plan" as it does not exclude certain coverages, such as limited dental or vision care. (However, as noted below, coverage through an HMO must be for comprehensive health care services, thus, limited dental or vision care under a separate policy is not an HMO in any event.)

d. Consideration provided to participating providers is capitated.

In addition to these statutory definitions, CR 05-59 defines a "limited scope plan" in s. Ins 9.01 (10m). The significant feature of this definition is that it is a "health care plan" that provides ***limited-scope dental or vision benefits*** under a separate policy, certificate, or contract of insurance. (Since this is not a "health benefit plan" under s. 609.01 (1g) (b) 9., Stats., a limited scope plan is not a defined network plan.) CR 05-59 also imposes certain requirements on "limited scope plans."

The diagram in **Attachment 1** illustrates the relationships of various plans.

In addition to these types of plans, some insurers offer an indemnity plan which, in very general terms, is typically a health care plan that does not have participating providers and pays benefits on a fee-for-service basis if an enrollee receives covered health care services from any health care provider. This may be known as a standard plan.[2]

Also, some plans offer a point-of-service plan option that permits an enrollee to obtain covered health care services from a nonparticipating provider if the enrollee is responsible for additional costs or charges. [See s. 609.10, Stats.]

Insurers receive certificates of authority from OCI to offer certain types of plans. [s. 609.03, Stats.] In addition, OCI has authority to issue a certificate of authority that permits an insurer who would otherwise be limited to providing an HMO or LSHO to engage in another insurance business that is immaterial in relation to or incidental to the HMO or LSHO. [s. 609.03 (3) (a) 3. and (b), Stats.] For example, the analysis to CR 05-59 refers to an LSHO authorized to write no more than 10% of its premium as a PPP.

Statutory Requirements

The statutes impose requirements on the various types of plans. The statutes sometimes distinguish between all defined network plans versus the subset of defined network plans that are not PPPs. Notably, with regard to CR 05-59, the statutes impose certain requirements on defined network plans that are not PPPs but subject a PPP to these requirements if the PPP does not "cover the same services" when performed by a nonparticipating provider that it covers when performed by a participating provider. Part of the focus of CR 05-59 is to specify what "cover the same services" means for this purpose.

The statutory requirements affecting the plans that relate to significant aspects of CR 05-59 are briefly set forth in a chart in **Attachment 2**. It should be noted that the chart does not list all statutory requirements relating to the various types of plans affected by CR 05-59, many of which are outside of ch. 609, Stats., or are in ch. 609, Stats., but relate to mandated benefits or are not the primary subject of CR 05-59.

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[2] "Standard plan" is defined in s. 609.01 (7), Stats., as any health care plan other than an HMO or PPP. This may not be what is generally conceived of as a "standard plan" as it would include an LSHO, which is not generally considered to be a "standard plan."

Rule-Making Authority

OCI has general authority under s. 227.11 (2), Stats., to promulgate rules interpreting the statutes relating to insurance. [s. 601.41 (3), Stats.] Also, OCI is authorized to promulgate rules relating to defined network plans and PPPs for certain specified purposes. [s. 609.20, Stats.] In addition, OCI is required, by rule, to develop standards for defined network plans to comply with the requirements of ch. 609, Stats. [s. 609.38, Stats.]

In addition to this explicit rule-making authority, the statutes provide that policy forms generally must be filed with and approved by OCI before use and may be disapproved if a form is misleading because benefits are too restricted to achieve the purposes for which the policy is sold. [s. 631.20 (1) and (2) (a) 1., Stats.] Also, OCI may promulgate, by rule, authorized clauses for insurance forms upon a finding that reasonable minimum standards of insurance protection are needed for policies to serve a useful purpose. [s. 631.23, Stats.] OCI also may require insurers to provide statements, reports, answers to questionnaires, and other information, in whatever form designated by OCI, at such reasonable intervals as OCI chooses. [s. 601.42 (1g) (a), Stats.]

PROVISIONS OF CR 05-59

Attachment 3 lists various provisions of CR 05-59, as submitted by the Legislature that appear to be of particular significance. It includes information about what "cover the same services" means for the purpose of subjecting certain PPPs to requirements that would otherwise apply only to a defined network plan that is not a PPP.

COMMENTS ABOUT CR 05-59

This part of the memorandum lists my comments about CR 05-59 as submitted to the Legislature.[3] The comments generally relate to issues of clarity, technical drafting requirements, and consistency with the statutes. The comments do not include any policy issues that may be raised by a committee, including, for example, whether the coinsurance provisions in s. Ins 9.25 (1) are appropriate to define what constitutes covering the same service to determine whether a PPP must comply with additional statutory requirements.

1. SECTION 1 should not include the amendment to s. Ins 3.67 (1) (c) as it does not have the same treatment clause as the provisions being renumbered since it is not being renumbered. Instead a separate SECTION in the proposed rule should be created to reflect that "Ins 3.67 (1) (c) is being amended to read:" and "3.67 (1) (~~b~~c)" should be changed to "3.67 (1) (c)".

2. The proposed rule deletes most references to a LSHO and instead defines and refers to a "limited scope plan." As noted in the chart in Attachment 1, as defined in s. Ins 9.01 (10m), a limited scope plan may be a PPP that offers limited dental or vision services (and, by definition, is not a defined network plan) or an LSHO that offers limited dental or vision services. It is not clear why almost all the references to LSHO were deleted in the proposed changes to ch. Ins 9 as that would mean that other LSHOs (namely LSHO plans offering

[3] The comments do not address the analysis to CR 05-59 provided by OCI.

limited benefits other than dental or vision services) are not dealt with. It may be that the existence of such LSHOs is only theoretical and that none are being marketed. However, if they exist or there is a significant likelihood of their existing in the near future, it appears that the proposed rule should deal with them and not limit provisions to a limited scope plan.

Similarly, a PPP that is not a defined network plan could be either a limited scope plan under the proposed definition (because it offers only dental or vision coverage) or a PPP that offers limited coverage other than dental or vision services. Again, CR 05-59 does not always deal with the latter plans. Again, it may be that the existence of such plans is only theoretical and that none are being marketed. However, if they exist or there is a significant likelihood of their existing in the near future, it appears that the proposed rule should deal with them.

For example, s. Ins 9.20 indicates that subch. III, ch. Ins 9, applies to insurers offering a defined network plan or a limited scope plan. As another example, s. Ins 9.41 provides that an insurer offering a defined network plan or limited scope plan must treat a complaint as a grievance at the request of OCI. Neither provision addresses an LSHO that is other than dental or vision or a PPP that provides limited coverage under a separate policy that is limited to other than dental or vision.

3. The definition of PPP in s. Ins 9.01 (15) not only refers to the statutory definition, it inappropriately includes substantive requirements, that is, it provides that in order to be a PPP, the plan must comply with the same service requirements and additional requirements in CR 05-59. According to s. 1.01 (7) of the "Administrative Rules Procedure Manual," substantive provisions cannot be included in a definition. Moreover, these substantive requirements would inappropriately change the statutory definition.

4. Section 609.35, Stats., provides that a PPP 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 PPPs. Section Ins 9.25 (1) provides that, for the purposes of s. 609.35, Stats., a PPP 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 insured complies with all six subsections in s. Ins 9.25. The following comments apply to these provisions:

    a. The title of s. Ins 9.25 mischaracterizes the same service provisions as "requirements." It would be less confusing to refer to them as "provisions" inasmuch as PPPs may choose not to cover the same services and voluntarily subject themselves to certain statutory requirements. This means that the subsections in s. Ins 9.25 should not be drafted as requirements, that is: (1) the word "shall" should be deleted in s. Ins 9.25 (1) (intro.), (2) (intro.), (3), and (6); and (2) the phrase "required to provide" in s. Ins 9.25 (5) should be changed to "providing". Also, the title to s. Ins 9.27 should not include the term "additional" in "additional requirements" since the provisions in s. Ins 9.25 are not requirements. Also, in s. Ins 9.25 (1) to (6), the references in the subsections to "insurers" should be changed to "the insurer" to be consistent with s. Ins 9.25 (intro.).

b. Section Ins 9.25 (4) does not follow the structure used by the other subsections as it does not set forth an action that the insurer may undertake to comply. This should be restructured to flow from s. Ins 9.25 (intro.).

c. Section Ins 9.25 (2) permits an insurer to exceed the coinsurance, deductible, and co-payment differentials to the extent "reasonably necessary" to encourage use of participating providers or centers of excellence for transplant or other unique disease treatment under certain circumstances, preventive health care services limited to immunizations, and certain other services when the benefit would exceed specific mandated benefits under certain circumstances. 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."

   Also, as drafted, an insurer could not opt to provide the differential benefit only for either the centers of excellence or for the immunizations and exceeding specific mandated benefits because s. Ins 9.25 (2) (intro.) requires that notice be provided about both. This provision would have to be redrafted to allow an insurer to opt for only one such alternative.

d. In s. Ins 9.25 (3), it appears that "this subsection" should be changed to "this section".

e. Section Ins 9.25 (4) provides that if a PPP uses utilization management to deny access to or coverage for services of nonparticipating providers "without just cause" and "with such frequency as to indicate a general business practice," OCI will treat the PPP as a defined network plan and subject it to all requirements of a defined network plan. First, the phrase "defined network plan" should be changed to "defined network plan that is not a preferred provider plan" to make this consistent with the statutes cross-referenced in s. 609.35, Stats. Second, the rule does not specify how, on what basis, and by whom a determination is made that there is no "just cause" or when there is "such frequency as to indicate a general business practice" in order to trigger this consequence.

   A similar comment applies to s. Ins 9.37 (4) although that section does specify that OCI makes the determination.

5. In ss. Ins 9.25 (1) and (2) and 9.27 (1), (2), and (3), the paragraphs should be shown as "(a)" and "(b)", not "a." and "b."

6. A title is needed for s. Ins 9.26. Also, the phrase "defined network" should be changed to "defined network plan that is not a preferred provider plan" to be consistent with the statutes cross-referenced. Also, while s. Ins 9.26 appropriately cross-references all of the statutes with which a PPP that is not covering the same services must comply, s. Ins 9.26 additionally lists various sections in ch. Ins 9 with which such a PPP must comply. There is not exact alignment between these sections and the statutory provisions.

7. In s. Ins 9.27 (2) b., it appears that "2 times greater" should be changed to "more than 2 times greater" to be consistent with s. Ins 9.27 (2) a. Similarly, in s. Ins 9.27 (3) b., it appears that

"3 times greater" should be changed to "more than 3 times greater" to be consistent with s. Ins 9.27 (3) a.

8. In s. Ins 9.27 (3) a. and b., it appears that the word "deductible" should be changed to "co-payment" since it is the co-payment that is being compared.

9. In the Note to s. Ins 9.31, "par. (1) (a)" should be changed to "sub. (1)". Also, "par. (1) (b)" should be changed to "sub. (2)".

10. A title is needed for s. Ins 9.32.

11. Section Ins 9.32 (2) (f) does not follow the introductory language in s. Ins 9.32 (2) (intro.) requiring certain insurers to undertake certain actions. It should be included as a separate subsection, not a paragraph under sub. (2).

12. Section Ins 9.35 requires that certain notification be posted in the provider's office by a certain date. It does not specify for how long the notice must be posted.

13. Section Ins 9.40 (2) (b), (6), and (7) include provisions relating to a defined network plan that is neither an HMO nor PPP. I understood from a discussion with OCI staff that this could be a point-of-service plan offered by an indemnity insurer. It is not clear what part of the PPP definition in s. 609.01 (4), Stats., would not apply to such a plan. However, if a plan is not a PPP but is a defined network plan, all of the statutes relating to a defined network plan that is not a PPP (such as ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), Stats., as well as other statutes referring to all defined network plans) apply to such plans. This may not be the intended result.

14. SECTION 20 should indicate that "Ins 9.40 (1) (c)" is being repealed, not "Ins 9.42 (1) (c)".

15. Various grammar issues include:

    a. In the last sentence of s. Ins 9.07, a comma should be inserted following "secrets".

    b. In s. Ins 9.32 (2) (e) (intro.), "occur" should be changed to "occurs".

    c. In s. Ins 9.37 (3), "permit" should be changed to "permits". Also, "limit" should be changed to "limits".

    d. In s. Ins 9.37 (4), "than preferred" should be changed to "than a preferred".

Committee Options

As noted above, both committees currently have jurisdiction over the rule. A committee may do any of the following while it has jurisdiction:

1. Do nothing. OCI may then submit the rule to the Revisor of Statutes after the jurisdiction for both committees expires.

2. Vote to waive jurisdiction. (This action is almost never taken as a committee typically lets its jurisdiction expire if it has no objections.)

3. Vote to object to the rule. The rule is then referred to the Joint Committee for Review of Administrative Rules (JCRAR). If either committee does so, the other committee's jurisdiction ceases and that committee may take no action other than to also object.

4. Vote to request modifications. The committee's jurisdiction is preserved under this alternative only if OCI agrees in writing before the committee's jurisdiction expires that OCI will make (or consider making) modifications. (A committee may request specific modifications or may be less specific about the modifications requested.)

5. Vote to request modifications with a contingent objection, namely, that if OCI does not agree in writing before the committee's jurisdiction expires that OCI will make (or consider making) modifications, the committee objects to the rule. If OCI does not agree in writing by that date, then the rule is referred to JCRAR. (If a committee wants to object unless the agency agrees that it will make modifications, this approach has the advantage of not requiring a second executive session.)

If you have any questions, please feel free to contact me at 266-3137, or Senior Analyst David Lovell (266-1537), who staffs the Senate Committee.

JLK:ksm

Attachments

Attachment 1

TYPES OF PLANS AFFECTED BY CLEARINGHOUSE RULE 05-59[1]

PPP-Limited to Dental or Vision (No referral required; not capitated; coverage for participating and nonparticipating providers, but incentives to use participating providers)

PPP-Limited Benefits Other Than Dental or Vision (No referral required; not capitated; coverage for participating and nonparticipating providers, but incentives to use participating providers)

DEFINED NETWORK PLAN

(HEALTH BENEFIT PLAN (DOES NOT INCLUDE SEPARATE LIMITED BENEFITS); REQUIRES OR CREATES INCENTIVES TO USE PARTICIPATING PROVIDERS)

PPP-Comprehensive Health Care Services	Health Maintenance Organization (HMO)	Defined Network Plan-Other Than HMO or PPP
(No referral required; not capitated; coverage for participating and nonparticipating providers, but incentives to use participating providers)	(Comprehensive health care services; capitated; coverage only for use of participating providers)	(CR 05-59 refers to such entities in proposed s. Ins 9.40 (2) (b), (6), and (7))

LSHO

LSHO-Limited to Dental or Vision	LSHO-Limited Benefits Other Than Dental or Vision
(Capitated; coverage only for use of participating providers)	(Capitated; coverage only for use of participating providers)

Key

Defined Network Plan

Preferred Provider Plan (PPP)

Limited Service Health Organization (LSHO)

Limited Scope Plan (as defined in proposed s. Ins 9.01 (10m) in Clearinghouse Rule 05-59)

Prepared by Joyce L. Kiel, Senior Staff Attorney
Legislative Council Staff
October 12, 2005

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[1] The charts are not intended to represent the proportion of plans being underwritten in each category. Some types of plans may not currently be offered by insurers.

ATTACHMENT 2

Certain Statutory Requirements Relating to Clearinghouse Rule 05-59 (CR 05-59)[1]

	1. All Defined Network Plans	2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)[2]	3. PPP That Is a Defined Network Plan	4. PPP That Is Not a Defined Network Plan	5. PPP That Does Not "Cover The Same Services"[3]	6. Limited Service Health Organization
Number/Types of Providers	Include sufficient number and types of qualified providers to meet anticipated needs, as appropriate to type of plan and consistent with normal practices and standards in geographic area. [s. 609.22 (1), Stats.]	Yes -- See column 1.	Yes -- See column 1.	No[4]	N/A[5]	No
Adequate Choice	No	Ensure adequate choice among participating providers; ensure they are accessible and qualified. [s. 609.22 (2), Stats.]	No	No	Yes -- Same as column 2.	No

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[1] This chart does not discuss all statutory requirements that apply to plans affected by CR 05-59.

[2] This column includes a defined network plan that is neither a PPP nor a health maintenance organization (HMO). (This third category is referred to in proposed s. Ins 9.40 (2) (b), (6), and (7) in CR 05-59.)

[3] "Cover the same services" refers to the provision in s. 609.35, Stats., that a PPP 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 a defined network plan that is not a PPP.

[4] "No" means no explicit statutory provision.

[5] "N/A" means not applicable.

	1. All Defined Network Plans	2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)[2]	3. PPP That Is a Defined Network Plan	4. PPP That Is Not a Defined Network Plan	5. PPP That Does Not "Cover The Same Services"[3]	6. Limited Service Health Organization
Primary Provider and Selection of Primary Provider	Plan may require enrollee to designate primary provider and obtain services from primary provider when reasonably possible (except for: obstetric and gynecology services, as noted below; subject to provision for referral to specialists for plans in columns 2 and 5, as noted below. [s. 609.05 (2), Stats.]	Yes -- Same as column 1. Also, must: permit selection from list of participating providers; keep list updated; have sufficient number of primary providers accepting new enrollees. [s. 609.22 (3), Stats.]	Yes -- See column 1.	Yes -- Same as column 1.	Yes -- Same as column 2.	Yes -- Same as column 1.
Specialist Providers	May require referral from primary provider prior to obtaining services from another participating provider (who may be a specialist)--except for obstetric and gynecology services,	Yes -- Same as column 1. Also, may require referral from primary provider to specialist; if required, establish procedure for standing referral to specialist; secondary referrals may be restricted without primary provider	Yes -- See column 1.[6]	Yes -- Same as column 1.[6]	Yes -- Same as column 2.	Yes -- Same as column 1.

[6] The statutes appear to be inconsistent in that the definition of a PPP in s. 609.01 (4), Stats., indicates that services are available "without referral," but s. 609.05 (3), Stats., permits a PPP to require a referral in certain circumstances.

	1. All Defined Network Plans	2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)[2]	3. PPP That Is a Defined Network Plan	4. PPP That Is Not a Defined Network Plan	5. PPP That Does Not "Cover The Same Services"[3]	6. Limited Service Health Organization
Specialist Providers (cont.)	court-ordered mental health services, and emergency and urgent care for dependent child student outside plan area. [s. 609.05 (3), Stats.]	approval; include referral information in policies and certificates and upon request. [s. 609.22 (4), Stats.]				
Obstetric and Gynecologic Services	If covered, obstetric and gynecologic services from participating provider who specializes in those may be obtained without referral from primary provider. [s. 609.22 (4m), Stats.	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No
Second Opinions	Required coverage of second opinions from participating provider. [s. 609.22 (5), Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No
Emergency Care	If covered, emergency medical services covered without prior authorization and also urgent care for dependent child student outside plan area. [s. 609.22 (6), Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No

	1. All Defined Network Plans	2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)[2]	3. PPP That Is a Defined Network Plan	4. PPP That Is Not a Defined Network Plan	5. PPP That Does Not "Cover The Same Services"[3]	6. Limited Service Health Organization
Telephone Access	No	Provide telephone access during business and evening hours to provide access to routine health care services; provide 24-hour telephone access to plan or participating provider for emergency care or authorization of care. [s. 609.22 (7), Stats.]	No	No	Yes -- Same as column 2.	No
Access Plan for Underserved Populations	Required. [s. 609.22 (8), Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No
Continuity of Care	Subject to certain exceptions, required. [s. 609.24, Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No
Quality Assurance Standards	No	Develop quality assurance standards that include certain specified elements, including procedure for remedial action to address quality problems. [s. 609.32 (1), Stats.]	No	No	Yes -- Same as column 2.	No
Remedial Action to Address Quality Problems	No	Yes -- See above under "Quality Assurance Standards."	Develop remedial action procedure to address quality problems. [s. 609.32 (1m), Stats.]	Yes -- Same as column 3.	Yes -- See above under "Quality Assurance Standards."	No

	1. All Defined Network Plans	2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)[2]	3. PPP That Is a Defined Network Plan	4. PPP That Is Not a Defined Network Plan	5. PPP That Does Not "Cover The Same Services"[3]	6. Limited Service Health Organization
Medical Director	No	Medical director required; must be physician; is responsible for clinical protocols, quality assurance activities, and utilization management policies. [s. 609.34 (1), Stats.]	May contract for utilization management and clinical protocols. Physician medical director required only if PPP or its designee assumes direct responsibility for clinical protocols and utilization management policies of plan. [s. 609.34 (2), Stats.]	Yes -- Same as column 3.	Yes -- Same as column 2.	No
Information and Data Reporting	Provide OCI with information relating to: structure of plan; plan benefits and exclusions; cost-sharing requirements; and participating providers. [s. 609.36, Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No

Prepared by Joyce L. Kiel, Senior Staff Attorney
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October 12, 2005

Attachment 3

Listing of Certain Provisions in Clearinghouse Rule 05-59

This attachment lists the provisions of Clearinghouse Rule 05-59 (CR 05-59) that appear to be substantive in nature. It does not list provisions that: (a) are primarily editorial and do not result in a significant substantive change; or (b) change references to "managed care plans" to the phrase "defined network plans" as a consequence of the enactment of 2001 Wisconsin Act 16.

CR 05-59 includes provisions that do the following:

1. "Cover the Same Services" Provisions for Preferred Provider Plans (PPPs)

A. Specify the consequences if a PPP does not "cover the same services." [s. Ins 9.26] (As amended by 2001 Wisconsin Act 16, a PPP that does not "cover the same services" when performed by a nonparticipating provider that it covers when performed by a participating provider is made subject to certain requirements that otherwise apply only to a defined network plan that is not a PPP, namely: (1) ss. 609.22 (2) (adequate choice); (2) 609.22 (3) (primary provider selection); (3) 609.22 (4) (specialist provider provisions); (4) 609.22 (7) (telephone access); (5) 609.32 (1) (quality assurance provisions); and 609.34 (1), Stats. (medical director).[1])

B. Set forth the criteria for determining if a PPP is covering the same services, namely that the insurer does all of the following: [s. Ins 9.25]

1) Provides a coinsurance rate for nonparticipating providers that is 60% or more with the enrollee paying 40% or less; ***or*** provides a coinsurance rate for nonparticipating providers that is 50% or more with the enrollee paying 50% or less and the insurer provides a specified disclosure notice at the time of solicitation and prominently includes notice in the certificate or policy (hereinafter referred to as disclosure notice).

2) Applies material exclusions equally to participating and nonparticipating providers.

3) Exceeds coinsurance, co-payment, and deductible differentials (discussed in item 2., below) only to the extent "reasonably necessary" to encourage use of participating providers and centers of excellence for transplants and other unique diseases, immunizations, and for services above certain mandated benefits and only if certain disclosures are made.

4) Uses no financial incentives other than maximum limits, out-of-pocket limits, and certain coinsurance, co-payment, and deducible differentials (discussed in item 2., below) to encourage use of participating providers.

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[1] Additional information about these requirements is provided in Attachment 2.

5) Does not use utilization management (including preauthorization or similar methods) for denying access to or coverage of nonparticipating providers "without just cause" or "with such frequency as to indicate a general business practice."

6) Files certification with the Office of the Commissioner of Insurance (OCI) that the above conditions are complied with.

2. *ADDITIONAL REQUIREMENTS FOR INSURERS OFFERING A PPP*

A. Require all insurers offering a PPP to do all of the following: [s. Ins 9.27]

1) If a different coinsurance is applied to nonparticipating providers than participating providers, the coinsurance differential must be 30% or less; ***or*** if greater, then disclosure notice must be provided. (Exception if disclosure is provided about centers of excellence or coverage over certain mandated benefits, as noted in item 1., B., 3), above.)

2) If a different deductible is applied to nonparticipating providers than participating providers, the deductible differential must be no more than two times greater or no more than $2,000 greater; ***or*** if greater, then disclosure notice must be provided. (Exception if disclosure is provided about centers of excellence or coverage over certain mandated benefits, as noted in item 1., B., 3), above.)

3) If a different co-payment is applied to nonparticipating providers than participating providers, the co-payment differential must be no more than three times greater or no more than $100 greater for a health care provider and no more than $300 greater for a health care facility; ***or*** if greater, then disclosure notice must be provided. (Exception if disclosure is provided about centers of excellence or coverage over certain mandated benefits, as noted in item 1., B., 3), above.)

3. *ACCESS STANDARDS FOR A DEFINED NETWORK PLAN THAT IS NOT A PPP AND FOR PPPS THAT DO NOT "COVER THE SAME SERVICES"*

A. Require a defined network plan that is not a PPP and require a PPP that does not "cover the same services," as discussed in item 1., above, to do all of the following: [ss. Ins 9.26 and 9.32 (1)]

1) Provide benefits with reasonable promptness as to geographic location, hours of operation, waiting times for appointments, and after-hours care—which must reflect the usual practice in the local area and usual medical travel times in the community.

2) Have sufficient number and types of plan providers to adequately deliver services, based on demographics and health status of enrollees.

3) Provide 24-hour nationwide toll-free telephone access for enrollees and providers for authorization of care.

4) Cover emergency services for emergency medical condition by a nonparticipating provider as though provided by participating provider under certain circumstances.

B. Require annual certification to OCI of compliance with these access standards. [s. Ins 9.31 (1)]

4. *ACCESS STANDARDS FOR PPPS*

A. Require PPPs to do all of the following: [s. Ins 9.32 (2)]

1) Provide benefits with reasonable promptness as to geographic location, hours of operation, waiting times for appointments, and after-hours care—which must reflect the usual practice in the local area and usual medical travel times in the community. However, PPPs are not required to offer geographic availability of a choice of participating providers.

2) Provide sufficient number and types of participating providers to adequately deliver services, based on demographics and health status of enrollees, including at least one primary care provider and one participating provider with expertise in obstetrics and gynecology accepting new enrollees.

3) Include in all contracts with participating providers in Wisconsin or border counties of contiguous states who serve Wisconsin enrollees a provision requiring the provider who schedules an elective procedure or scheduled nonemergency care to disclose to an enrollee at the time of scheduling the name of each provider that will or may participate in the care and whether each is a participating or nonparticipating provider.

4) Prominently include in the provider directory a notice that includes the text specified in CR 05-59 (Appendix D to ch. Ins 9) about participating and nonparticipating providers.

5) Provide benefits provided by a nonparticipating provider involved in such elective procedure or scheduled nonemergency care by using co-payment, coinsurance, deductible, or other cost-sharing provisions that would otherwise be applicable to a participating provider ***if***: (a) the insurer does not include the provisions in item 3), above, in the provider contract; (b) the provider fails to comply with the contract by disclosing this information; or (c) the notice in item 4), above, is not included in the provider directory.

6) Cover emergency services for emergency medical condition by nonparticipating provider as though provided by participating provider under certain circumstances.

B. Require annual certification to OCI of compliance with these access standards. [s. Ins 9.31 (2)]

5. *QUALITY ASSURANCE AND REMEDIAL ACTION PLANS; GRIEVANCES AND COMPLAINTS*

A. Delete the requirement in current rules that PPPs establish and maintain a quality assurance committee and have that committee review complaints, appeals, and grievances. [Amendments to s. Ins 9.40 (4)]

B. Require a defined network plan that is not a PPP to have such a committee and have that committee review complaints, OCI complaints, appeals, and grievances. [s. Ins 9.40 (4)]

C. Delete the requirement in current rules that PPPs submit a quality assurance plan. [Amendments to s. Ins 9.40 (2) (a) and (3)] Instead, require that insurers offering a PPP develop procedures for taking effective and timely remedial action to address issues arising from quality problems, including access to, and continuity of care from, participating primary care providers. Also, require a remedial action plan that contains certain elements. [s. Ins 9.40 (3)]

D. Require a defined network plan that is neither a health maintenance organization (HMO) nor PPP to submit a quality assurance plan to OCI by April 1, 2007, and by April 1 of each subsequent year. [s. Ins 9.40 (2) (b)]

E. Amend the current requirement that every managed care plan include a summary of its quality assurance plans in its marketing material and a brief summary of the plan and a statement of patient rights and responsibilities in its certificate of coverage or enrollment materials to specify that the requirement applies only to a defined network that is an HMO. Additionally, require that insurers offering a defined network plan that is neither an HMO nor PPP comply with these requirements by April 1, 2008. [s. Ins 9.40 (7)]

F. Apply the revised definition of "grievance" only to defined network plans and limited scope plans. (This deletes application of the current provision about grievances to: (1) a PPP that offers limited coverage under a separate contract for other than dental or vision; and (2) a limited service health organization (LSHO) that covers services other than dental or vision.) [s. Ins 9.01 (5)]

G. Provide that defined network plans and limited scope plans must treat and process an OCI complaint (a written complaint received by OCI by an enrollee) like a grievance if OCI requests it. [s. Ins 9.41] (CR 05-59 also notes that insurers are responsible for compliance with the statutory internal grievance procedure requirement in s. 632.83, Stats. [s. Ins 9.42])

6. *DATA SUBMISSION*

A. Delete the requirement that a PPP that was a managed care plan under prior statutes submit a standardized data set to OCI beginning June 1, 2004, and no later than June 15 of each year. [Amendments to s. Ins 9.40 (6)]

B. Require that every insurer offering a defined network plan that is neither an HMO nor PPP submit a standardized data set specified by OCI beginning June 1, 2008. [s. Ins 9.40 (6)] (Note: HMOs have been required to submit Health Plan Employer Data and Information Set (HEDIS) or other standardized data specified by OCI since June 1, 2002.) [s. Ins 9.40 (5)]

7. *MISCELLANEOUS*

A. Clarify that a participating provider includes an intermediate entity. [s. Ins 9.01 (9m) and (14m)]

B. Clarify when copies of provider agreements are provided to OCI. [s. Ins 9.07]

C. Provide that a group insurance policy that covers a policyholder that is not a Wisconsin corporation and does not have its principal office in Wisconsin but covers 100 or more Wisconsin residents must comply with: (1) s. 609.22 (2), Stats. (adequate choice of providers provision applicable to defined network plans that are not PPPs and to PPPs that do not cover the same services); and (2) s. Ins 9.32 (2) (certain requirements applicable to PPPs). [s. Ins 9.30]

D. Provide that PPPs may comply with statutory continuity of care notifications that apply to all defined network plans or may contract with participating providers to provide notice to enrollees of their statutory rights. [s. Ins 9.35 (1m)]

E. With respect to criteria for standing referral to a specialist that applies to a defined network plan that is not a PPP and to a PPP that does not "cover the same services," specify that referral includes prior authorization for services if the insurer uses prior authorization or similar methods to deny standing referrals to specialists without "just cause" and with "such frequency to indicate a general business practice," as determined by OCI. [s. Ins 9.37 (4)]

F. Provide that the changes in the rules set forth in CR 05-59 apply to policies or certificates issued on or after January 1, 2007 and to policies renewed on or after January 1, 2008. [SECTION 26 of CR 05-59]

Prepared by Joyce L. Kiel, Senior Staff Attorney
Legislative Council Staff
October 12, 2005

Comments on Clearinghouse Rule 05-059 –Relating to revising requirements for insurers offering defined network plans, preferred provider plans and limited services health organization plans.

Areas of concern:

9.01 (10m) Limited scope plan

- Newly included in the version sent over from OCI
- Unclear why OCI singled out this type of health plan to include and not other types that are listed in statutes 609.01(1g)(9)

9.01(15) Silent provider networks

- Newly included in the version sent over from OCI
- Unclear what the Commissioner is referring to with this language. These silent networks are exempted from:
  - 609.22 – Access Standards
  - 609.24 – Continuity of Care
  - 609.32 – Quality Assurance
  - 609.34 – Requirement of a Medical Director
  - 609.36 – Data Reporting to OCI
  - 609.83 – Process for physician may add new drugs to a drug list

9.01(15) Definition of Preferred Provider Plan (PPP)

- The definition section of the rule is for substantive definitions
- Adding the language below expands the statutory definition of a Preferred Provider Plan (PPP)
    - *"...and the insurer offering a preferred provider plan does not require a referral to obtain coverage for care from either a participating or nonparticipating provider and complies with ss. Ins 9.25, 9.27 and 9.32 (2)."*

9.25 Preferred Provider Plan Same Service Requirements AND
9.27 Preferred Provider Plan Additional Requirements

- This language outlines what type of plans will be offered in the market place
  - The floor co-insurance is the 60% / 40% plan where insurance covers 60% of the cost of services to doctors outside the PPP network and the policy holder covers 40% of the cost
    - Across the nation the average plan is 50% / 50% coverage
  - The floor for co-insurance differential amount is 30% or less for doctors inside the network or out-side the network
  - The floor for deductibles is 2 times greater than the deductible or no more than $2000 higher than participating providers
  - The floor for co-payments is no more than 3 times greater than a deductible applied to participating providers or no more than $100 for services of a provider or $300 for a services of a health care facility

- Difficult to administer these sections of rule since OCI does not collect this information when a PPP submits their health plan for approval. Information would have to be obtained either through a market conduct examination or the complaints process
- Outlining the plan designs may impact premiums pay out by the policy holder due to cost of administering the new requirements and re-issuing of health care policies
- No similar guidelines for Point of Service Plans or HMO (HMOs greatly restrict coverage for out of network coverage)
    - Most states that regulate the plans **only regulate the differential** *(means: the difference between in and out of network co-insurance)*
- Requires a disclosure (more like a warning label) for plans that are below the OCI determined threshold for co-insurance, deductibles and co-pays
    - OCI has made this requirement effective upon renewal
    - Affects existing contracts – the company must send out a disclosure to all policy holders if the plan falls under the 50% co-insurance category.
    - Only applied to PPP and not POS or HMO
    - These disclosures may have a chilling effect on the market
- This is a substitutive issue included in the rule

9.31 Access Standards

- The legislation that passed removed the PPPs from particular sections of statutes (*Statutes 609.22 (2) , (3), (4), and (7)*) but through this administrative rule they are rolled back into these sections
    - The language is found in **9.32(2)**

9.32(2)(c), 9.32(2) e) and 9.32(2)(f) Disclosure of all providers that might be used in a medical procedure

- Requires that the doctor must disclose to the patient the names of every doctor that might be involved in the medical procedure and whether they are inside the network or not
- If the doctor fails to inform the patient, then all the costs will be covered at the in-network price
- This language makes the assumption that PPP have contractual control over the doctors that provide the service – which is inaccurate only an HMO has this level of control with the doctors in their networks

9.32(2)(g) Emergency Room coverage

- Any emergency room service provided to a patient under an emergency medical condition must be covered as an in-network cost
    - Not included in the statutory requirements for any health benefits plan or health care plan (which includes: HMO, PPO, POS)
    - Statute 609.22(6) includes language only that services provided on an emergency basis does not require on prior authorization
- This is a policy decision as indicated in Legislative Council Memo

Appendix D: Disclosure Notice

- Unclear why this disclosure would only apply to PPPs and not other types of health benefits plans or health care plans
- OCI provides specific language that must be used in the disclosure
    - If the rational for this language is that policy holders should understand the differences between various types of health plans then in consumer's best interest for OCI to have a pamphlet / website that consumers can used to determine the policy type (HMO, PPP, POS, LSHO, etc) that best meets their needs and an insurance sales persons can referred consumers to when selling a policy
- Disclosures can have a chilling effect in the market

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

The following are the WAPN compromises and changes to CR05-059

1. The inclusion of limited scope plans.

~~**9.01 (10m)** "Limited scope plan" means an insurer offering a health care plan that provides limited-scope dental or vision benefits under a separate policy, certificate or contract of insurance in accordance with s. 632.745 (11) (b) 9., Stats.~~

Drafter's Note: With the removal of this provision, you should also remove all references to limited scope plans found in 9.01 (5), 9.01 (9m), 9.01 (13), 9.07, 9.20, 9.41, 9.42,

9.01 (15) "Preferred provider plan" has the meaning provided under s. 609.01 (4) Stats. ~~and the insurer offering a preferred provider plan does not require a referral to obtain coverage for care from either a participating or nonparticipating provider and complies with ss. Ins 9.25, 9.27 and 9.32 (2).~~

2. Preferred provider plan same service requirements & 2a. The expectation of "substantial coinsurance coverage".

9.25 Preferred provider plan same service requirements. For purposes of s. 609.35, Stats., an insurer offering a preferred provider plan covers the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider only if the insurer complies with all of the following:

(1) Insurers offering a preferred provider plan shall provide coverage ~~that complies with either of the following:~~
~~a. Provides coverage for services performed by nonparticipating providers with the insurer paying at a coinsurance rate of not less than 60% and the enrollee paying at a coinsurance rate of not more than 40%.~~
~~b. Provides coverage~~ for services performed by nonparticipating providers with the insurer paying at a coinsurance rate not less than 50% and the enrollee paying at a coinsurance rate of not more than 50% ~~and the insurer provides the enrollee with the disclosure notice that is compliant with sub. (5)~~.

(2) Insurers offering a preferred provider plan shall equally apply material exclusions regardless if the services are performed by either participating or nonparticipating providers. Insurers may exceed the coinsurance differential in s. Ins 9.27 (1)~~, or the deductible differential in s. Ins 9.27 (2), or the co-payment differential in s. Ins 9.27 (3)~~ 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 the minimum required for specific mandated benefits under ss. 632.895 and 632.89, Stats., when the insurer at the time of solicitation and within the policy, does both of the following:
a. Provides a disclosure to enrollees that identify the centers of excellence and the specific covered benefits that are covered at a different rate if provided by a health care provider that is recognized and identified as a center of excellence.
b. Clearly and prominently discloses that immunizations or expanded benefits above mandated minimum coverage are covered when performed by participating providers or with greater disparity than permitted in s. Ins 9.27 (1) ~~through (3)~~.

~~**9.25 (5)** An insurer required to provide a disclosure notice under sub. (1) shall provide the disclosure notice to the applicant at the time of solicitation, and shall include in a prominent location within the certificate of coverage issued under a group policy and in a prominent location in an individual policy, the following form and in not less than 11-point bold font:~~
~~**"NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered service, benefit payments to such nonparticipating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical are where the services are performed), or other method as defined by the policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND CO-PAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Nonparticipating providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than co-payment, coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling [the toll free telephone] number on your identification card [or visiting [the company's] website].**~~

Drafter's Note: With the removal of this provision, you should also remove all references to 9.25(5), and renumber 9.25(6) to 9.25(5). In addition, WAPN would agree to a compromise to include the language found in this provision in a "Consumers Guide on Defined Network Plans" issued by the OCI discussing out of network limitations on all Defined Network Plans. As an alternative to this compromise, WAPN would also be willing to include this language within the rule if it would apply equally to all Defined Network Plans, and upon review and approval of such draft language.

2b. **The pre-authorization provision".**

~~**9.25 (4)** Insurers offering a preferred provider plan that uses utilization management, including preauthorization or similar methods, for denying access to or coverage of the services of nonparticipating providers without just cause and with such frequency as to indicate a general business practice, such methods shall result in the plan being treated by the commissioner as a defined network plan and subject to all requirements of a defined network plan.~~

Drafter's Note: With the removal of this provision, WAPN would agree to a compromise to include language that would allow the OCI to review this issue through the complaint process and report back to the legislature in a certain period of time as to any documented problems with insurers using pre-authorization for denying access.

3. The expectation of additional "substantial coverage" provisions.

Ins 9.27 Preferred provider plan additional requirements. Insurers offering a preferred provider plan shall comply with ~~all the following~~:
(1) Except as provided in s. Ins 9.25 (2), insurers offering a preferred provider plan that apply a coinsurance percentage when the services are performed by nonparticipating providers at a different percentage than the coinsurance percentage that is applied when the services are performed by participating providers shall offer plans that have ~~either of the following:~~
~~a. T~~the coinsurance differential between participating and nonparticipating providers performing the same services is ~~3~~40% or less.
~~b. The coinsurance differential between participating and nonparticipating provider performing the same services is greater than 30% and the insurer provides the enrollee with a disclosure notice that is compliant with s. Ins 9.25 (5).~~
~~**(2)** Except as provided in s. Ins 9.25 (2), insurers offering a preferred provider plan that apply a deductible when the services are performed by nonparticipating providers in a different amount than the deductible that is applied when the services are performed by participating providers shall offer plans that have either of the following:~~
~~a. The deductible applied to nonparticipating providers is no more than 2 times greater than the deductible applied to participating providers or no more than $2000 higher than the participating provider deductible.~~
~~b. The deductible applied to nonparticipating providers is 2 times greater than the deductible applied to participating providers or is more than $2000 higher than the participating provider deductible and the insurer provides the enrollee with a disclosure notice that is compliant with s. Ins 9.25 (5).~~
~~**(3)** Except as provided in s. Ins 9.25 (2), insurers offering a preferred provider plan that apply a co-payment when the services are performed by nonparticipating providers in a different amount than the co-payment that is applied when the services are performed by participating providers shall offer plans that have either of the following:~~
~~a. The co-payment applied to nonparticipating providers is no more than 3 times greater than the deductible applied to participating providers or no more than $100 for services of a health care provider or no more than $300 for services of a health care facility.~~
~~b. The co-payment applied to nonparticipating providers is 3 times greater than the deductible applied to participating providers or is more than $100 for services of a health care provider or is more than $300 for services of a health care facility and the insurer provides the enrollee with a disclosure notice that is compliant with s. Ins 9.25 (5).~~

4. The inclusion of PPP's in Access Standards.

~~**9.32 (2)** An insurer offering a preferred provider plan shall do all of the following:~~
~~**(a)** Provide covered benefits by participating providers with reasonable promptness with respect to geographic location, hours of operation, waiting times for appointments in provider offices and after hours care. The hours of operation, waiting times, and availability of after~~

~~hours care shall reflect the usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community. This does not require an insurer offering a preferred provider plan to offer geographic availability of a choice of participating providers.~~
~~**(b)** Provide sufficient number and type of participating providers to adequately deliver all covered services based on the demographics and to meet the anticipated needs of its enrollees served by the plan including at least one primary care provider and a participating provider with expertise in obstetrics and gynecology accepting new enrollees.~~

Drafter's Note: With the removal of this provision, you should also remove all references to 9.32(2)(a) and 9.32(2)(b).

5. The inclusion of PPP's in new provisions of Access Standards.

~~**9.32 (2)(c)** Include in all contracts with participating providers that are located in Wisconsin or located in the border counties of contiguous states and provide services to Wisconsin enrollees, a provision requiring the participating provider that schedules an elective procedure or other scheduled non-emergency care to fully disclose to the enrollee at the time of scheduling the name of each provider that will or may participate in the delivery of the care and whether each provider is a participating or nonparticipating provider.~~
~~**(e)** Provide the covered benefits provided by nonparticipating providers involved in the scheduled elective or non-emergency scheduled care at the rate the insurer pays a nonparticipating provider after applying any co-payments, coinsurance, deductibles or other cost-sharing provisions that apply to participating providers when the enrollee receives care from a nonparticipating provider and either of the following occur:~~
~~1. The insurer fails to comply with par. (c). Failure of the insurer includes the failure of its participating provider to comply with the terms of the contract.~~
~~2. The insurer fails to comply with par. (d).~~
~~**(f)** Nothing in this section changes the reimbursement payable or the amounts due, including co-payments, coinsurance, deductibles and other cost-sharing provisions from an enrollee when the enrollee elects to utilize the services of a nonparticipating provider when a participating provider is available in accordance with pars. (a) and (b) and the requirements of pars. (c) and (d), including the information from the participating provider, are provided to the enrollee.~~

Drafter's Note: With the removal of this provision, you should also remove all references to 9.32(2)(c), 9.32(2)(e) and 9.32(2)(f)

6. Provider Directories and Appendix D.

9.32 (2)(d) Include in its provider directory a prominent notice that complies with language that is substantially similar to the language found in Appendix D ~~and is printed in 11-point bold font~~.

9.37 Notice requirements. (1) PROVIDED INFORMATION. Prior to enrolling members, insurers offering a defined network plan shall provide to prospective group or individual policyholders information on the plan including all of the following:
(2) PROVIDER DIRECTORIES. Insurers offering a defined network plan shall make current provider directories available to enrollees upon enrollment, and no less than annually, following the first year of enrollment. Preferred provider plans shall also include language that is substantially similar to the language of Appendix D.

7. Emergency Services Provision.

9.32 (2)(g) Provide as a covered benefit the emergency services rendered during the treatment of an emergency medical condition, as defined by s. 632.85, Stats., by a nonparticipating provider as though the services were provided by a participating provider, if the insurer provides coverage for emergency medical services and the enrollee cannot reasonably reach a participating provider or, as a result of the emergency, is admitted for inpatient care, subject to any restriction that may govern payment to a participating provider for emergency services. The insurer shall pay the nonparticipating provider at the rate the insurer pays a nonparticipating provider after applying any co-payments, coinsurance, deductibles or other cost-sharing provisions that apply to participating providers. *For the purposes of this provision, 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.*

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

Delete the inclusion of limited scope plans

Delete 9.01 (10m)

Compromise on preferred provider plan same service requirements

Agree to a coinsurance floor of 50%; and either:

> Delete the disclosure language within the regulation and have the OCI develop a consumers guide to out of network coverages for defined network plans,
>
> Or,
>
> Leave the disclosure language in the regulation but have it apply equally to all defined network plans.

Compromise on pre-authorization provision

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

Compromise on additional "substantial coverage" provisions

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

> Delete the disclosure language within the regulation and have the OCI develop a consumers guide to out of network coverages for defined network plans,
>
> Or,
>
> Leave the disclosure language in the regulation but have it apply equally to all defined network plans.

Delete the inclusion of PPP's in Access Standards

Delete 9.32 (2)(a) & (2)(b)

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

Delete 9.32 (2)(c), (2)(e) & (2)(f)

Compromise on Provider Directories and Appendix D

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

Agree to Emergency Services Provision

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

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

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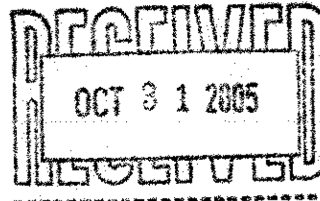


October 31, 2005

Honorable Dan Kapanke
State Senator
104 South Capitol
Madison WI 53701

Dear Senator Kapanke:

I have reviewed the motion adopted by the Senate Committee on Agriculture and Insurance, requesting OCI to modify CR 05-59 at their meeting on October 26. Although the Senate Committee did not prepare a specific list of modifications for consideration; the concerns of the Wisconsin Association of Provider Networks (WAPN) were attached to the motion. OCI's response to each of the points raised in the attachment is as follows:

Inclusion of limited scope plans. OCI met with representatives of limited scope plans affected by the rule. These representatives assured OCI that the rule will not impose undue hardship on limited scope plans. The proposed rule permits limited scope plans to meet the less stringent regulatory requirements of a preferred provider plan.

Restriction on Referral Requirement. The statutory definition of a preferred provider plan in s. 609.01(4), Wis. Stat., specifically states that referrals are not permitted. The rule simply restates this restriction.

Same service and substantial coinsurance coverage. WAPN's proposal allows an insurer to restrict coverage to only 50% of the usual and customary charges of a non-participating provider without providing access to a higher level of coverage for services from a participating provider. OCI's rule already includes this proposal because it allows insurers to offer, and consumers to chose, this restricted coverage. Now WAPN asks that OCI eliminate the disclosure that makes this an informed consumer choice. Major affected insurers in the state have acknowledged that this disclosure is appropriate. The proposal is not in the interest of consumers or the insurance industry.

Substantial coverage provisions. WAPN's proposal eliminates any clear explanation to insurers or consumers as to what constitutes a preferred provider plan. Similar to the substantial coinsurance provision, the OCI proposed rule outlines the requirements an insurer must meet to offer a policy with severely limited benefits.

Inclusion of preferred provider plans in access standards. WAPN's proposal eliminates any requirement for a preferred provider plan to maintain an adequate provider network. This can not be justified either under the applicable statutes or to affected consumers.

Inclusion of preferred provider plan access standards. WAPN's proposal eliminates the requirement that the consumer receive critical information at the time an elective procedure is

scheduled. The proposed rule requires only that consumers be told in advance that there is a possibility that services provided at a participating facility may not all be covered at participating provider rates. As documented in OCI complaints, consumers are frequently surprised to discover that, despite their best efforts to use participating providers, not every provider at a participating facility is a participating provider. Again this provision was developed with the participation of major Wisconsin insurers and has their support.

Provider directories. It is not clear to OCI why any insurer would be opposed to making their provider directories readily available to its insured members. This language simply makes clear what the expectation is for providing this information.

Emergency services provision. WAPN's proposal appears to reflect the current Medicare guidelines. Wisconsin already has clear statutory language defining an emergency situation in s. 632.85, Wis. Stat., that applies to all health insurance products. The new language does not appear to add any clarity.

As you know, OCI met and negotiated the language in the proposed rule with interested parties, including legislative staff, over a period of nearly a year. A representative of WAPN was invited to all the open meetings and attended most of them. In this process, OCI made significant concessions and has been willing to compromise. The interested parties were able to reach a consensus on the language in the proposed rule that has been submitted to the Legislature. OCI has also given careful consideration to, and addressed, issues raised by legislative council staff.

The four largest insurers that offer preferred provider plan products in Wisconsin have agreed to the language submitted by my office. As a result, I am reluctant to take any action that would result in the unraveling of the consensus reached by this group. Respect for the efforts of the participating parties to negotiate in good faith, and compelling concern for consumers, demand that OCI not agree to modify the proposed rule. Accordingly, OCI declines to modify the rule.

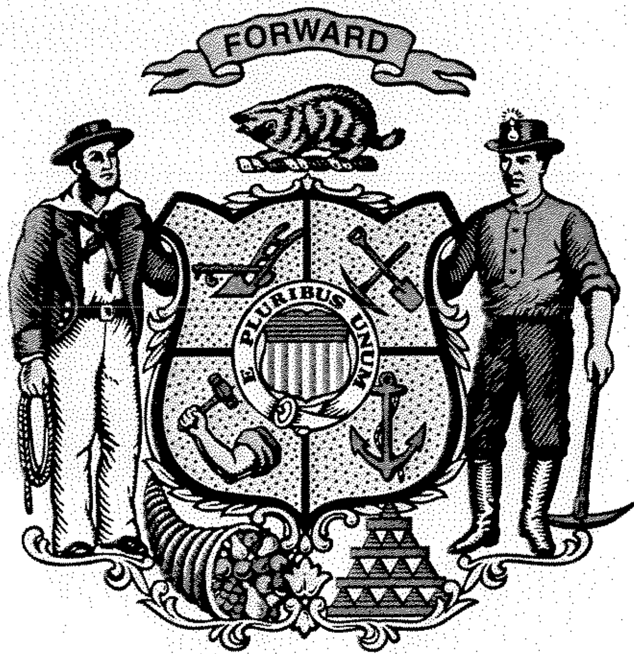
I would be happy to meet with you to discuss your concerns you may have regarding the proposed rule.

Sincerely,

Jorge Gómez
Commissioner

JAG/em

Cc: Senator Neal Kedzie
Senator Ronald Brown
Senator Luther Olsen
Senator Jon Erpenbach
Senator Dave Hanson
Senator Mark Miller


FORWARD
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12-12-05

WISCONSIN LEGISLATIVE COUNCIL

Terry C. Anderson, Director
Laura D. Rose, Deputy Director

TO: MEMBERS OF THE JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

FROM: Joyce L. Kiel, Senior Staff Attorney

RE: Clearinghouse Rule 05-59, Relating to Revising Requirements for Insurers Offering Defined Network Plans, Preferred Provider Plans, and Limited Service Health Organizations in Order to Comply With Recent Changes in State Laws

DATE: December 12, 2005

This memorandum relates to Clearinghouse Rule 05-59 (CR 05-59), relating to revising requirements for insurers offering defined network plans, preferred provider plans (PPPs), and limited service health organizations (LSHOs) in order to comply with recent changes in state laws. The memorandum does the following:

- Describes the procedural background of CR 05-59.
- Provides general background information about: defined network plans, health maintenance organizations (HMOs), PPPs, and LSHOs; statutes affecting them that relate to this proposed rule; and the authority of the Office of the Commissioner of Insurance (OCI) to promulgate rules relating to insurers offering such plans.
- Describes the provisions of CR 05-59.

PROCEDURAL BACKGROUND

OCI submitted CR 05-59 in response to 2001 Wisconsin Act 16, which, in pertinent part, eliminated the use of the term "managed care plan" and substituted the term "defined network plan" and made various changes to ch. 609, Stats., which now relates to defined network plans.

Following OCI's submission of CR 05-59 to the Legislature, the rule was referred to the Assembly Committee on Insurance and to the Senate Committee on Agriculture and Insurance. The committees held a joint public hearing on the rule. On October 13, 2005, the Assembly committee voted (Ayes, 9; Noes, 2) to request that OCI consider making modifications to the rule with a contingent objection that if OCI did not notify the Assembly committee chair by November 7, 2005 that OCI would consider doing so, the Assembly committee objected to the rule.

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On October 17, 2005, OCI submitted modifications. Because modifications were received subsequent to the Assembly committee's request for modifications and the Assembly committee took no further action, the Assembly committee's contingent objection was not triggered.

On October 26, 2005, the Senate committee voted (Ayes, 7; Noes, 0) to request that OCI consider making modifications to the rule with a contingent objection that if OCI did not notify the Senate committee chair by October 31, 2005 that OCI would consider doing so, the Senate committee objected to the rule. OCI did not submit modifications following the Senate committee's action. In a letter to the Senate committee chair dated October 31, 2005, OCI indicated that it declined to further modify the rule. This triggered the Senate committee's contention objection, and the rule was referred to the Joint Committee for Review of Administrative Rules.

GENERAL BACKGROUND

Currently, ch. Ins 9, Wis. Adm. Code, relates to managed care plans. Subsequent to the passage of 2001 Wisconsin Act 16, OCI submitted Clearinghouse Rule 02-69 (CR 02-69) to propose amendments to ch. Ins 9, Wis. Adm. Code, to refer to defined network plans, rather than managed care plans, and to implement the changes made by Act 16. The chairs of both of the committees to which CR 02-69 was referred (the Assembly Committee on Health and the Senate Committee on Insurance, Tourism, and Transportation) requested a meeting with OCI. OCI subsequently submitted several modifications to CR 02-69.

However, OCI eventually withdrew CR 02-69 without ever promulgating it. In 2004, OCI attempted to proceed with CR 02-69 but discontinued the initiative after the Legislative Council Clearinghouse indicated that there was no statutory process for resubmitting a withdrawn rule to the Legislature.

OCI has now submitted CR 05-59 to change references in the Administrative Code from managed care plan to defined network plan and to implement the changes made by Act 16.

Definitions of Types of Plans

CR 05-59 relates to several types of plans offered by insurers: defined network plan, HMO, PPP, and LSHO. Each type of plan is defined in the statutes. [See s. 609.01 (1b), (2), (4), and (3), Stats., respectively.) The matter may be somewhat confusing as some of the types of plans include part, but not all, of another type of plan. For example, most, but not all, PPPs are a defined network plan.

The most significant features of the pertinent statutory definitions are as follows:

1. ***Defined network plan***—s. 609.01 (1b), Stats. Significant features include:

    a. Is a "health ***benefit*** plan," as defined in s. 609.01 (1g), Stats. (Any hospital or medical policy or certificate, but ***excluding***: certain coverage when provided under a separate policy, certificate, or contract, such as ***limited-scope dental or vision*** benefits, or benefits for nursing home care, health care, community-based care, or any combination of these; certain other types of insurance specified in s. 609.01 (1g) (b), Stats.; and other insurance exempted by OCI by rule.)

    b. Requires or creates incentives for enrollees to use certain health care providers that are managed, owned, under contract with, or employed by the insurer (collectively referred to as participating providers).

2. ***HMO***—s. 609.01 (2), Stats. Significant features include:

a. Is a "health *care* plan," as defined in s. 609.01 (1m), Stats. (Any insurance contract covering health care expenses.)[1]

b. Provides ***comprehensive*** health care services.

c. Coverage for services performed by ***participating*** providers.

d. Consideration provided to participating providers is predetermined periodic fixed payments (commonly referred to as capitated payment).

3. ***PPP***—s. 609.01 (4), Stats. Significant features include:

a. Is a "health ***care*** plan."

b. Coverage can be ***comprehensive*** health care services ***or limited*** range of health care services (for example, dental or vision coverage under a separate policy).

c. Coverage ***regardless*** of whether the services are performed by a ***participating or nonparticipating provider.*** (PPPs typically create incentives (usually in the form of higher benefits) for an enrollee to receive services from a participating provider. Unless a PPP is providing limited services in a separate policy, a PPP comes under the definition of a defined network plan.)

d. Consideration provided to participating providers is ***not*** capitated. (As a matter of practice, a participating provider may have agreed to charge less than the provider's standard fee-for-service rate for a service rendered to a PPP enrollee.)

e. Services must be available ***without referral.***

4. ***LSHO***—s. 609.01 (3), Stats. Significant features include:

a. Is a "health ***care*** plan."

b. Provides ***limited*** health care services.

c. Coverage for services performed by ***participating*** providers.

d. Consideration provided to participating providers is capitated.

In addition to these statutory definitions, CR 05-59 defines a "limited scope plan" in s. Ins 9.01 (10m). The significant feature of this definition is that it is a "health care plan" that provides ***limited scope dental or vision benefits*** under a separate policy, certificate, or contract of insurance. (Since this is not a "health benefit plan" under s. 609.01 (1g) (b) 9., Stats., a limited scope plan is not a defined network plan.) CR 05-59 also imposes certain requirements on "limited scope plans."

The diagram in **Attachment 1** illustrates the relationships of various plans.

In addition to these types of plans, some insurers offer an indemnity plan which, in very general terms, is typically a health care plan that does not have participating providers and pays benefits on a

[1] This definition is broader than a "health benefit plan" as discussed above as it does not exclude certain coverages, such as limited scope dental or vision. (However, as noted below, coverage through an HMO must be for comprehensive health care services, thus, limited scope dental or vision benefits under a separate policy is not an HMO in any event.)

fee-for-service basis if an enrollee receives covered health care services from any health care provider. This may be known as a standard plan.[2]

Also, some plans offer a point-of-service plan option that permits an enrollee to obtain covered health care services from a nonparticipating provider if the enrollee is responsible for additional costs or charges. [See s. 609.10, Stats.]

Insurers receive certificates of authority from OCI to offer certain types of plans. [s. 609.03, Stats.] In addition, OCI has authority to issue a certificate of authority that permits an insurer who would otherwise be limited to providing an HMO or LSHO to engage in another insurance business that is immaterial in relation to or incidental to the HMO or LSHO. [s. 609.03 (3) (a) 3. and (b), Stats.] For example, the analysis to CR 05-59 refers to an LSHO authorized to write no more than 10% of its premium as a PPP.

Statutory Requirements

The statutes impose requirements on the various types of plans. The statutes sometimes distinguish between all defined network plans versus the subset of defined network plans that are not PPPs. Notably, with regard to CR 05-59, the statutes impose certain requirements on defined network plans that are not PPPs but subject a PPP to these requirements if the PPP does not "cover the same services" when performed by a nonparticipating provider that it covers when performed by a participating provider. Part of the focus of CR 05-59 is to specify what "cover the same services" means for this purpose.

The statutory requirements affecting the plans that relate to significant aspects of CR 05-59 are briefly set forth in a chart in **Attachment 2**. The chart does not list all statutory requirements relating to the various types of plans affected by CR 05-59, many of which are outside of ch. 609, Stats., or are in ch. 609, Stats., but relate to mandated benefits or are not the primary subject of CR 05-59.

Rule-Making Authority

OCI has general authority under s. 227.11 (2), Stats., to promulgate rules interpreting the statutes relating to insurance. [s. 601.41 (3), Stats.] Also, OCI is authorized to promulgate rules relating to defined network plans and PPPs for certain specified purposes [s. 609.20, Stats.]; OCI is required to develop, by rule, standards for defined network plans to comply with the requirements of ch. 609, Stats. [s. 609.38, Stats.]; and OCI may exempt, by rule, insurance from the definition of "health benefit plan" which would have the effect of exempting such insurance from the definition of defined network plan. [s. 609.01 (1g) (b) 11., Stats.]

In addition to this explicit rule-making authority, the statutes provide that policy forms generally must be filed with and approved by OCI before use and may be disapproved if a form is misleading because benefits are too restricted to achieve the purposes for which the policy is sold. [s. 631.20 (1) and (2) (a) 1., Stats.] Also, OCI may promulgate, by rule, authorized clauses for insurance forms upon a finding that reasonable minimum standards of insurance protection are needed for policies to serve a useful purpose. [s. 631.23, Stats.] OCI also may require insurers to provide statements, reports, answers to questionnaires, and other information, in whatever form designated by OCI, at such reasonable intervals as OCI chooses. [s. 601.42 (1g) (a), Stats.]

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[2] "Standard plan" is defined in s. 609.01 (7), Stats., as any health care plan other than an HMO or PPP. This may not be what is generally conceived of as a "standard plan" as it would include an LSHO, which is not generally considered to be a "standard plan."

PROVISIONS OF CR 05-59

The following is a list of substantive provisions of CR 05-59 as submitted to the Legislature (including the modifications submitted on October 17, 2005) that appear to be of particular significance. The list does not include provisions that: (a) are primarily editorial and do not result in a significant substantive change; or (b) change references to "managed care plans" to the phrase "defined network plans" as a consequence of the enactment of 2001 Wisconsin Act 16. CR 05-59 includes provisions that do the following:

1. "Cover the Same Services" Provisions for PPPs

As amended by 2001 Wisconsin Act 16, a PPP that does not "cover the same services" when performed by a nonparticipating provider that it covers when performed by a participating provider is made subject to certain requirements that otherwise apply only to a defined network plan that is not a PPP. CR 05-59 provisions relating to this do the following:

A. Set forth the criteria for determining if a PPP is covering the same services, namely that the insurer does all of the following: [s. Ins 9.25]

   1) Provides a coinsurance rate for nonparticipating providers that is 60% or more with the enrollee paying 40% or less; ***or*** provides a coinsurance rate for nonparticipating providers that is 50% or more with the enrollee paying 50% or less and the insurer provides a specified disclosure notice at the time of solicitation and prominently includes notice in the certificate or policy (hereinafter referred to as disclosure notice).

   2) Applies material exclusions equally to participating and nonparticipating providers.

   3) Exceeds coinsurance, co-payment, and deductible differentials (discussed in item 2., below) only to the extent the insurer reasonably determines the cost sharing is necessary to encourage use of participating providers and centers of excellence for transplants and other unique diseases, immunizations, and for services above certain mandated benefits and only if certain disclosures are made.

   4) Uses no financial incentives other than maximum limits, out-of-pocket limits, and certain coinsurance, co-payment, and deducible differentials (discussed in item 2., below) to encourage use of participating providers.

   5) Does not use utilization management (including preauthorization or similar methods) for denying access to or coverage of nonparticipating providers "without just cause" or "with such frequency as to indicate a general business practice," as determined by OCI.

   6) Files certification with OCI that the above conditions are complied with.

B. Specify the consequences if a PPP does not "cover the same services" [s. Ins 9.26], namely requires compliance with: ss. 609.22 (2) (adequate choice); 609.22 (3) (primary provider selection); 609.22 (4) (specialist provider provisions); 609.22 (7) (telephone access); 609.32 (1) (quality assurance provisions); and 609.34 (1), Stats. (medical director).[3] These replicate the requirements in s. 609.35, Stats. CR 05-59 also requires compliance with: ss. Ins 9.31 (annual certification of access standards); 9.32 (1) (requirements for defined network plan that is not a PPP); 9.35 (1) (continuity of care provisions for a defined network plan); 9.37

[3] Additional information about these requirements is provided in Attachment 2.

(4) (standing referral criteria for a defined network plan that is not a PPP); 9.40 (2) (submission of quality assurance plan); 9.40 (4) (quality assurance committee); 9.40 (6) standardized data set submission to OCI beginning June 1, 2008); and 18.03 (2) (c) 1. (grievance procedures).

2. Additional Requirements for Insurers Offering a PPP

A. Require all insurers offering a PPP to do all of the following: [s. Ins 9.27]

1) If a different coinsurance is applied to nonparticipating providers than participating providers, the coinsurance differential must be 30% or less; ***or*** if greater, then disclosure notice must be provided. (Exception if disclosure is provided about centers of excellence or coverage over certain mandated benefits, as noted in item 1., A., 3), above.)

2) If a different deductible is applied to nonparticipating providers than participating providers, the deductible differential must be no more than two times greater or no more than $2,000 greater; ***or*** if greater, then disclosure notice must be provided. (Exception if disclosure is provided about centers of excellence or coverage over certain mandated benefits, as noted in item 1., A., 3), above.)

3) If a different co-payment is applied to nonparticipating providers than participating providers, the co-payment differential must be no more than three times greater or no more than $100 greater for a health care provider and no more than $300 greater for a health care facility; ***or*** if greater, then disclosure notice must be provided. (Exception if disclosure is provided about centers of excellence or coverage over certain mandated benefits, as noted in item 1., A., 3), above.)

3. Access Standards for a Defined Network Plan That Is Not a PPP and for PPPs That Do Not "Cover the Same Services"

A. Require a defined network plan that is not a PPP and require a PPP that does not "cover the same services," as discussed in item 1., above, to do all of the following: [ss. Ins 9.26 and 9.32 (1)]

1) Provide benefits with reasonable promptness as to geographic location, hours of operation, waiting times for appointments, and after-hours care—which must reflect the usual practice in the local area and usual medical travel times in the community.

2) Have sufficient number and types of plan providers to adequately deliver services, based on demographics and health status of current and expected enrollees.

3) Provide 24-hour nationwide toll-free telephone access for enrollees and providers for authorization of care.

4) Cover emergency services for emergency medical condition by a nonparticipating provider as though provided by participating provider under certain circumstances.

B. Require annual certification to OCI of compliance with these access standards. [s. Ins 9.31 (1)]

4. Access Standards for PPPs

A. Require PPPs to do all of the following: [s. Ins 9.32 (2)] (A PPP that does not "cover the same services" is subject to item 3., above.)

1) Provide benefits with reasonable promptness as to geographic location, hours of operation, waiting times for appointments, and after-hours care—which must reflect the usual practice in the local area and usual medical travel times in the community. However, PPPs are not required to offer geographic availability of a choice of participating providers.

2) Provide sufficient number and types of participating providers to adequately deliver services, based on demographics and to meet anticipated needs of enrollees, including at least one primary care provider and one participating provider with expertise in obstetrics and gynecology accepting new enrollees.

3) Include in all contracts with participating providers in Wisconsin or border counties of contiguous states who serve Wisconsin enrollees a provision requiring the provider who schedules an elective procedure or scheduled nonemergency care to disclose to an enrollee at the time of scheduling the name of each provider that will or may participate in the care and whether each is a participating or nonparticipating provider.

4) Prominently include in the provider directory a notice that includes the text specified in CR 05-59 (Appendix D to ch. Ins 9) about participating and nonparticipating providers.

5) Provide benefits provided by a nonparticipating provider involved in such elective procedure or scheduled nonemergency care by using co-payment, coinsurance, deductible, or other cost-sharing provisions that would otherwise be applicable to a participating provider ***if***: (a) the insurer does not include the provisions in item 3), above, in the provider contract; (b) the provider fails to comply with the contract by disclosing this information; or (c) the notice in item 4), above, is not included in the provider directory.

6) Cover emergency services for emergency medical condition by nonparticipating provider as though provided by participating provider under certain circumstances.

B. Require annual certification to OCI of compliance with these access standards. [s. Ins 9.31 (2)]

5. Quality Assurance and Remedial Action Plans: Grievances and Complaints

A. Delete the requirement in current rules that PPPs establish and maintain a quality assurance committee and have that committee review complaints, appeals, and grievances. [Amendments to s. Ins 9.40 (4)]

B. Require a defined network plan that is not a PPP to have such a committee and have that committee review complaints, OCI complaints, appeals, and grievances. [s. Ins 9.40 (4)]

C. Delete the requirement in current rules that PPPs submit a quality assurance plan. [Amendments to s. Ins 9.40 (2) (a) and (3)] Instead, require that insurers offering a PPP develop procedures for taking effective and timely remedial action to address issues arising from quality problems, including access to, and continuity of care from, participating primary care providers. Also, require a remedial action plan that contains certain elements. [s. Ins 9.40 (3)]

D. Require a defined network plan that is neither a health maintenance organization (HMO) nor PPP to submit a quality assurance plan to OCI by April 1, 2007, and by April 1 of each subsequent year. [s. Ins 9.40 (2) (b)]

E. Amend the current requirement that every managed care plan include a summary of its quality assurance plans in its marketing material and a brief summary of the plan and a statement of patient rights and responsibilities in its certificate of coverage or enrollment materials to specify that the requirement applies only to a defined network that is an HMO. Additionally, require that insurers offering a defined network plan that is neither an HMO nor PPP comply with these requirements by April 1, 2008. [s. Ins 9.40 (7)]

F. Apply the revised definition of "grievance" only to defined network plans and limited scope plans. (This deletes application of the current provision about grievances to: (1) a PPP that offers limited coverage under a separate contract for other than dental or vision; and (2) a limited service health organization (LSHO) that covers services other than dental or vision.) [s. Ins 9.01 (5)]

G. Provide that defined network plans and limited scope plans must treat and process an OCI complaint (a written complaint received by OCI by an enrollee) like a grievance if OCI requests it. [s. Ins 9.41] (CR 05-59 also notes that insurers are responsible for compliance with the statutory internal grievance procedure requirement in s. 632.83, Stats. [s. Ins 9.42])

6. Data Submission

A. Delete the requirement that a PPP that was a managed care plan under prior statutes submit a standardized data set to OCI beginning June 1, 2004, and no later than June 15 of each year. [Amendments to s. Ins 9.40 (6)]

B. Require that every insurer offering a defined network plan that is neither an HMO nor PPP submit a standardized data set specified by OCI beginning June 1, 2008. [s. Ins 9.40 (6)] Also, apply this requirement to a PPP that does not "cover the same services." [s. Ins. 9.26.] (Note: HMOs have been required to submit Health Plan Employer Data and Information Set (HEDIS) or other standardized data specified by OCI since June 1, 2002.) [s. Ins 9.40 (5)]

7. Miscellaneous

A. Clarify that a participating provider includes an intermediate entity. [s. Ins 9.01 (9m) and (14m)]

B. Clarify when copies of provider agreements are provided to OCI. [s. Ins 9.07]

C. Provide that a group insurance policy that covers a policyholder that is not a Wisconsin corporation and does not have its principal office in Wisconsin but covers 100 or more Wisconsin residents must comply with: (1) s. 609.22 (2), Stats. (adequate choice of providers provision applicable to defined network plans that are not PPPs and to PPPs that do not cover the same services); and (2) s. Ins 9.32 (2) (certain requirements applicable to PPPs). [s. Ins 9.30]

D. Provide that PPPs may comply with statutory continuity of care notifications that apply to all defined network plans or may contract with participating providers to provide notice to enrollees of their statutory rights. [s. Ins 9.35 (1m)]

E. With respect to criteria for standing referral to a specialist that applies to a defined network plan that is not a PPP and to a PPP that does not "cover the same services," specify that referral includes prior authorization for services if the insurer uses prior authorization or similar methods to deny standing referrals to specialists without "just cause" and with "such frequency to indicate a general business practice," as determined by OCI. [s. Ins 9.37 (4)]

F. Provide that the changes in the rules set forth in CR 05-59 apply to policies or certificates issued on or after January 1, 2007 and to policies renewed on or after January 1, 2008. [SECTION 27 of CR 05-59]

If you have any questions, please feel free to contact me at the Legislative Council Staff offices.

JLK:ksm:tlu:rv

Attachments

Attachment 1

TYPES OF PLANS AFFECTED BY CLEARINGHOUSE RULE 05-59[4]

DEFINED NETWORK PLAN
(HEALTH BENEFIT PLAN (DOES NOT INCLUDE SEPARATE LIMITED BENEFITS); REQUIRES OR CREATES INCENTIVES TO USE PARTICIPATING PROVIDERS)

PPP-Limited to Dental or Vision (No referral required; not capitated; coverage for participating and nonparticipating providers, but incentives to use participating providers)

PPP-Limited Benefits Other Than Dental or Vision (No referral required; not capitated; coverage for participating and nonparticipating providers, but incentives to use participating providers)

PPP-Comprehensive Health Care Services (No referral required; not capitated; coverage for participating and nonparticipating providers, but incentives to use participating providers)

Health Maintenance Organization (HMO) (Comprehensive health care services; capitated; coverage only for use of participating providers)

Defined Network Plan-Other Than HMO or PPP (CR 05-59 refers to such entities in proposed s. Ins 9.40 (2) (b), (6), and (7))

LSHO

LSHO-Limited to Dental or Vision (Capitated; coverage only for use of participating providers)

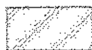
LSHO-Limited Benefits Other Than Dental or Vision (Capitated; coverage only for use of participating providers)

Key

Defined Network Plan

Preferred Provider Plan (PPP)

Limited Service Health Organization (LSHO)


Limited Scope Plan (as defined in proposed s. Ins 9.01 (10m) in Clearinghouse Rule 05-59)

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December 12, 2005

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[4] The charts are not intended to represent the proportion of plans being underwritten in each category. Some types of plans may not currently be offered by insurers.

ATTACHMENT 2

Certain Statutory Requirements Relating to Clearinghouse Rule 05-59 (CR 05-59)[5]

	1. All Defined Network Plans	**2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)**[6]	**3. PPP That Is a Defined Network Plan**	**4. PPP That Is Not a Defined Network Plan**	**5. PPP That Does Not "Cover The Same Services"**[7]	**6. Limited Service Health Organization**
Number/Types of Providers	Include sufficient number and types of qualified providers to meet anticipated needs, as appropriate to type of plan and consistent with normal practices and standards in geographic area. [s. 609.22 (1), Stats.]	Yes -- See column 1.	Yes -- See column 1.	No[8]	N/A[9]	No
Adequate Choice	No	Ensure adequate choice among participating providers; ensure they are accessible and qualified. [s. 609.22 (2), Stats.]	No	No	Yes -- Same as column 2.	No

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[5] This chart does not discuss all statutory requirements that apply to plans affected by CR 05-59.

[6] This column includes a defined network plan that is neither a PPP nor a health maintenance organization (HMO). (This third category is referred to in proposed s. Ins 9.40 (2) (b), (6), and (7) in CR 05-59.)

[7] "Cover the same services" refers to the provision in s. 609.35, Stats., that a PPP 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 a defined network plan that is not a PPP.

[8] "No" means no explicit statutory provision.

[9] "N/A" means not applicable.

	1. All Defined Network Plans	2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)[6]	3. PPP That Is a Defined Network Plan	4. PPP That Is Not a Defined Network Plan	5. PPP That Does Not "Cover The Same Services"[7]	6. Limited Service Health Organization
Primary Provider and Selection of Primary Provider	Plan may require enrollee to designate primary provider and obtain services from primary provider when reasonably possible (except for: obstetric and gynecology services, as noted below; subject to provision for referral to specialists for plans in columns 2 and 5, as noted below.) [s. 609.05 (2), Stats.]	Yes -- Same as column 1. Also, must: permit selection from list of participating providers; keep list updated; and have sufficient number of primary providers accepting new enrollees. [s. 609.22 (3), Stats.]	Yes -- See column 1.	Yes -- Same as column 1.	Yes -- Same as column 2.	Yes -- Same as column 1.
Specialist Providers	May require referral from primary provider prior to obtaining services from another participating provider (who may be a specialist)--except for obstetric and gynecology services,	Yes -- Same as column 1. Also, may require referral from primary provider to specialist; if required, establish procedure for standing referral to specialist; secondary referrals may be restricted without primary provider	Yes -- See column 1.[10]	Yes -- Same as column 1.[6]	Yes -- Same as column 2.	Yes -- Same as column 1.

[10] The statutes appear to be inconsistent in that the definition of a PPP in s. 609.01 (4), Stats., indicates that services are available "without referral," but s. 609.05 (3), Stats., permits a PPP to require a referral in certain circumstances.

	1. All Defined Network Plans	2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)[6]	3. PPP That Is a Defined Network Plan	4. PPP That Is Not a Defined Network Plan	5. PPP That Does Not "Cover The Same Services"[7]	6. Limited Service Health Organization
Specialist Providers (cont.)	court-ordered mental health services, and emergency and urgent care for dependent child student outside plan area. [s. 609.05 (3), Stats.]	approval; include referral information in policies and certificates and upon request. [s. 609.22 (4), Stats.]				
Obstetric and Gynecologic Services	If covered, obstetric and gynecologic services from participating provider who specializes in those may be obtained without referral from primary provider. [s. 609.22 (4m), Stats.	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No
Second Opinions	Required coverage of second opinions from participating provider. [s. 609.22 (5), Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No
Emergency Care	If covered, emergency medical services covered without prior authorization and also urgent care for dependent child student outside plan area. [s. 609.22 (6), Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No

	1. All Defined Network Plans	2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)[6]	3. PPP That Is a Defined Network Plan	4. PPP That Is Not a Defined Network Plan	5. PPP That Does Not "Cover The Same Services"[7]	6. Limited Service Health Organization
Telephone Access	No	Provide telephone access during business and evening hours to provide access to routine health care services; provide 24-hour telephone access to plan or participating provider for emergency care or authorization of care. [s. 609.22 (7), Stats.]	No	No	Yes -- Same as column 2.	No
Access Plan for Underserved Populations	Required. [s. 609.22 (8), Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No
Continuity of Care	Subject to certain exceptions, required. [s. 609.24, Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No
Quality Assurance Standards	No	Develop quality assurance standards that include certain specified elements, including procedure for remedial action to address quality problems. [s. 609.32 (1), Stats.]	No	No	Yes -- Same as column 2.	No
Remedial Action to Address Quality Problems	No	Yes -- See above under "Quality Assurance Standards."	Develop remedial action procedure to address quality problems. [s. 609.32 (1m), Stats.]	Yes -- Same as column 3.	Yes -- See above under "Quality Assurance Standards."	No

	1. All Defined Network Plans	**2. Defined Network Plan That Is Not a Preferred Provider Plan (PPP)[6]**	**3. PPP That Is a Defined Network Plan**	**4. PPP That Is Not a Defined Network Plan**	**5. PPP That Does Not "Cover The Same Services"[7]**	**6. Limited Service Health Organization**
Medical Director	No	Medical director required; must be physician; is responsible for clinical protocols, quality assurance activities, and utilization management policies. [s. 609.34 (1), Stats.]	May contract for utilization management and clinical protocols. Physician medical director required only if PPP or its designee assumes direct responsibility for clinical protocols and utilization management policies of plan. [s. 609.34 (2), Stats.]	Yes -- Same as column 3.	Yes -- Same as column 2.	No
Information and Data Reporting	Provide OCI with information relating to: structure of plan; plan benefits and exclusions; cost-sharing requirements; and participating providers. [s. 609.36, Stats.]	Yes -- See column 1.	Yes -- See column 1.	No	N/A	No

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