Modifications From Agency

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

REPEALING, AMENDING AND CREATING A RULE

The Wisconsin Office of the Commission of Insurance proposes an order to repeal Ins 9.01 (10m), 9.32 (2) (f); to amend Ins 9.01 (5), (9m), and (13), 9.07 (1), Subchapter III (title), 9.20 (intro.), 9.25 (4), 9.32 (2) (a), 9.41, 9.42 (1) and (5) (a); and to create 9.015 and 9.32 (2) (fm), Wis. Adm. Code, relating to defined network plans, preferred provider plans, limited service health organizations and affecting small businesses.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. Statutes interpreted:

Sections 600.01, 628.34 (12) and 632.85, and ch. 609, Stats.

2. Statutory authority:

Sections 600.01(2), 601.41(3), 601.42, 609.20, 609.38 and 628.34(12), Stats.

3. Explanation of the OCI's authority to promulgate the proposed rule under these statutes:

The Commissioner of Insurance is authorized to promulgate rules under ss. 628.34 (12), 601.41 and 609.20, Stats. Section 609.20, Stats., permits the Commissioner to promulgate rules relating to preferred provider plans and defined network plans in order to ensure enrollee access to health care services and ensure continuity of health care while recognizing the differences between preferred provider plans and defined network plans.

4. Related Statutes or rules:

There are no related statutes or rules.

5. The plain language analysis and summary of the proposed rule:

The proposed rule:

1) Changes subchapter III title to reflect regulation of defined network, preferred provider and limited service health organization plans.
2) Eliminates the term "limited scope plan" from provisions governing defined network and preferred provider plans. The commissioner's intent is to

eliminate the application to limited scope plans of certain rules promulgated in Clearinghouse Rule 05-059 as evidenced by the creation of s. Ins 9.015 exempting certain limited scope plans from regulation under Ch. Ins 9.

3) Changes provisions governing improper utilization practices so as to prohibit improper practices but not deem the insurer a defined network plan. This provision will be enforced by the Office following expiration of the rule suspension.

4) Eliminates specific requirements relating to network location, hours, waiting times and availability of after hours care but retains the requirement that access must be reasonably prompt consistent with normal practices and standards in the area. This provision will be enforced by the Office following expiration of the rule suspension.

5) Repeals the emergency coverage section suspended by JCRAR.

6) Creates a requirement that insurers offering preferred provider plans cover at a participating provider rate emergency care received from non-participating providers until the nonparticipating provider has met its obligation to treat the enrollee under federal EMTALA law. This provision will be enforced by the Office following expiration of the rule suspension.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

There is no federal regulation that addresses the activities regulated by the proposed rule.

7. Comparison of similar rules in adjacent states as found by OCI:

Iowa: Iowa statute §514C.16, requires a carrier which provides coverage for emergency services to be responsible for charges for emergency services furnished outside any contractual provider network or preferred provider network for covered individuals. Iowa Administrative Code s. 191-27.4 (1)(a), requires a health benefit plan which provides for incentives for covered persons to use the health care services of a preferred provider to contain a provision that if a covered person receives emergency services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, emergency services rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider, subject to any restrictions which may govern payment to a preferred provider for emergency services. Iowa statute §514B and Administrative Code 191-40.21, require HMOs to reimburse a provider of emergency services after a review of the care and may not deny reimbursement solely on the grounds that the services were provided by non-contracted providers.

Iowa statute §514F.3 requires the commissioner of insurance to adopt rules for preferred provider contracts and organizations and to adopt rules related to preferred provider arrangements. Iowa statute §514K.1 requires HMOs, organized delivery systems or an insurer using a preferred provider arrangement to provide to its enrollees written information that at a minimum must include the following; a description

of the plan's benefits and exclusions, enrollee cost-sharing requirements, list of participating providers, disclosure of drug formularies, explanation for accessing emergency care services, policy for addressing investigational or experimental treatments, methodologies used to compensate providers, performance measures as determined by the commissioner and information on how to access internal and external grievance procedures. In addition the Iowa department must annually publish a consumer guide providing a comparison by plan on performance measures, network composition, and other key information to enable consumers to better understand plan differences.

Iowa Administrative Code 191-27.3 (1), requires preferred provider arrangements to establish the amount and manner of payment to a preferred provider, the mechanisms designed to minimize cost of the health benefits plan and ensure reasonable access to covered services under the preferred provider arrangement. Iowa Administrative Code 191-27.4 (1) (b), requires preferred provider plans to contain a provision that clearly identifies the differentials in benefit levels for health care services of preferred providers and non-preferred providers. Iowa Administrative Code 191-27.4 (2), requires that if a health benefit plan provides difference in benefit levels payable to preferred providers compared to other providers, such difference shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

Illinois: Illinois statutory code 215 ILCS 5/370o, requires any preferred provider contract to provide the enrollee emergency care coverage regardless of whether the emergency care is provided by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a plan provider. Section 215 ILCS 5/370i, sec. (a) prohibits policies from containing provisions that would unreasonably restrict the access and availability of health care services for the enrollee. Section 215 ILCS 134/40, sec. 40 (d) requires a health care plan to pay for services of a specialist with the enrollee only responsible for the services as though the services were provided by an in-network provider when the plan does not have the specialist that the enrollee needs for the care of an on-going specific condition. The primary care physician arranges for the enrollee to see a specialist that is within a reasonable distance and travel time and the primary provider notifies the plan of the referral.

The information required to be provided to consumers is contained in s. 215 ILCS 134/15, that requires annual reporting of participating health care providers in the plan's service area and in addition to basic terms of the plan, includes disclosure of out-of-area coverage, if any, financial responsibility of enrollees including co-payments, deductibles, premium and any other out-of-pocket expenses, continuity of care, appeal rights and mandated benefits. Illinois Administrative Code s. 5420.40, requires disclosure so that a person can compare the attributes of various health care plans based upon a description of coverage. This disclosure

includes that 2 appendices are completed that detail specific co-payments, coinsurance, deductibles, and other cost-sharing provisions for services that must be included with the policy for consumer information.

In addition to the worksheets that provide consumers with detailed information, Illinois statutory code s. 215ILCS 5/356z.2, also requires an insurer that issues or renews an individual or group accident and health policy and arranges, contracts with or administers contracts with providers whereby the beneficiary is provided an incentive to use the services of such provider to include the following disclosure of limited benefits in its contracts and evidence of coverage:

> WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating 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 area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members 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 services with no additional billing to the member other than co-insurance 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. (Emphasis in original.)

Illinois statute s. 215 ILCS 134/80 requires that health care plans have procedures for quality assessment program including in s. (3) and (4) that require plans to have a procedure for remedial action to correct quality problems that have been verified in accordance with the written plan's methodology and criteria, including written procedures for taking appropriate corrective action and follow-up measures implemented to evaluate the effectiveness of the action plan.

Illinois Administrative Code s. 5420.50 requires that all provider agreements contain provisions providing for advance notice from providers when terminating from the plan and requirements that the plan notify affected enrollees on a timely basis. The notice provided to the enrollee must contain information on how enrollees are to select a new health care provider.

Minnesota: Minnesota statute s. 62A.049, prohibits an accident and sickness policy from requiring prior authorization in cases of emergency confinement or emergency treatment. The enrollee or authorized representative must notify the insurer as soon as reasonably possible. Section 62Q.55 requires managed care organizations including preferred provider organization, to provide enrollees with available and accessible emergency services. Services shall be covered whether provided by participating or nonparticipating providers and whether provided within or outside the health plan's service area. Section 62D.20 and s. 4685.0700, Minnesota Administrative Code, require HMOs to provide out-of-area services including for emergency care.

Minnesota statute s. 62Q.49 (subd. 2) (a), requires all health plans to clearly specify how the cost of health care used to calculate any co-payments, coinsurance or lifetime benefits will be affected by the contracting in which health care providers agree to accept discounted charges. Further any marketing or summary materials must be disclosed prominently and clearly explain the provisions relating to co-payments, coinsurance or maximum lifetime benefits.

Minnesota statute s. 62Q.58, requires that if an enrollee receives services from a nonparticipating specialist because a participating specialist is not available, the services must be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received from a participating specialist.

Minnesota statute s. 62Q.746, permits the department to request and the health plan to provide the following information including how the plan determines who is eligible to participate in the network, the number of full-time equivalent physicians, by specialty, non-physician providers and allied health providers used to provide services and summary data that is broken down by type of provider reflecting actual utilization of network and non-network practitioners and allied professionals by enrollees of the plan.

Michigan: Michigan statute s. 500.3406k, requires an expense-incurred hospital, medical or surgical policy that provides coverage for emergency health services, including an HMO plan, to provide coverage for medically necessary services provided to an enrollee for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, that the absence of immediate care could reasonably be expected to result in serious jeopardy to health without prior authorization.

Insurers that contract with providers are governed by the Prudent Purchaser Act of 1984 including preferred provider organizations (MCL 550.50 et seq.). The organization that contracts with providers shall annually report to the commissioner basic utilization of the providers (MCL 550.56). Under MCL 550.53, organizations that contract with providers to control costs and utilization may limit the number of providers to the number necessary to assure reasonable levels of access to health care services, located within reasonable distance.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

The information OCI used in support of this proposed rule includes the information described in the analysis of Clearinghouse Rule 05-059. However more specifically it includes the information provided by representatives of the insurance industry, preferred provider organizations, and providers in a series of meetings, and in responses to OCI's requests for comments and information, concerning the topics addressed by the proposed rule.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

This rule does not impose any additional requirements on small businesses. Its effect will be to limit requirements otherwise applied by rules currently in effect, including Clearinghouse rule 05-059. This is apparent from the proposed rule itself and the summary.

10. If these changes may have a significant fiscal effect on the private sector, the anticipated costs that will be incurred by private sector in complying with the rule:

This rule will not have a significant fiscal effect on the private sector. Its effect will be to limit requirements otherwise applied by rules currently in effect, including Clearinghouse rule 05-059.

11. A description of the Effect on Small Business:

This rule will have an effect on small businesses only by limiting requirements otherwise applied by rules currently in effect, including Clearinghouse rule 05-059.

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the WEB sites at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: Inger.Williams@OCI.State.WI.US
Address: 125 South Webster St – 2nd Floor Madison WI 53702
Mail: PO Box 7873, Madison WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 8th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie Walsh
Legal Unit - OCI Rule Comment for Rule Ins
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Julie Walsh

Legal Unit - OCI Rule Comment for Rule Ins
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53702

Email address:

Julie Walsh
Julie.Walsh@oci.state.wi.us

WEB Site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Sections Ins 9.01 (5), (9m) and (13) are amended to read:

INS 9.01 (5) "Grievance" means any dissatisfaction with the provision of services or claims practices of an insurer offering a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization, or administration of a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization, that is expressed to the insurer by, or on behalf of, an enrollee.

(9m) "Intermediate entity" means a provider network, a provider association, a provider leasing arrangement or other similar entity that contracts with providers for the rendering of health care services, items or supplies to enrollees of a defined network plan, preferred provider plan or limited ~~scope plan~~ service health organization and also contracts with the insurer offering a defined network plan, preferred provider plan or limited ~~scope plan~~ service health organization.

(13) "OCI complaint" means any written complaint received by the office of the commissioner of insurance by, or on behalf of, an enrollee of an insurer offering a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization.

SECTION 2. Ins 9.01 (10m) is repealed.

SECTION 3. Ins 9.015 is created to read:

Ins 9.015 **Scope.** This chapter applies to all insurers offering a defined network plan, a preferred provider plan or a limited service health organization plan except to an insurer offering a preferred provider plan that also meets the subject matter of s. 632.745 (11) (b) 9., Stats.

SECTION 4. Subchapter III (title) is amended to read:

Subchapter III (title) – Market Conduct Standards for Defined Network Plans, Preferred Provider Plans and Limited Service Health Organizations.

SECTION 5. Ins 9.07 (1) is amended to read:

Ins 9.07 (1) Notwithstanding any claim of trade secret or proprietary information, all insurers offering a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization shall, upon request, from the commissioner, make available to the commissioner all executed copies of any provider agreements between the insurer and intermediate entities or individuals providers. Any party to a provider agreement may assert that a portion of the contracts contain trade secrets, and the commissioner may withhold that portion to the extent it may be withheld under s. Ins 6.13.

SECTION 6. Ins 9.20 (intro.) is amended to read:

Ins 9.20 (intro.) This subchapter applies to all insurers offering a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization in this state. The insurer shall ensure that the requirements of this subchapter are met by all defined network ~~or limited scope~~ plans, preferred provider plans or limited service health organizations issued by the insurer. The commissioner may approve an exemption to this subchapter for an insurer to market a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization if the insurer files the plan with the commissioner and the commissioner determines that all of the following conditions are met:

SECTION 7. Section Ins 9.25 (4) is amended to read:

Ins 9.25 (4) The insurer offering a preferred provider plan may use utilization management, including preauthorization or similar methods, for denying access to or coverage of services of nonparticipating providers with just cause and without such frequency as to indicate a general business practice. ~~Using utilization management, including preauthorization or similar methods, for denying access to or coverage of services of nonparticipating providers without just cause and with such frequency as to indicate a general business practice, as determined by the commissioner, results in the plan being treated by the commissioner as a defined network plan and subject to all requirements of a defined network plan. may not use utilization management techniques, including prior authorization requirements or similar methods, to deny access to nonparticipating providers.~~

NOTE: The commissioner intends to enforce this section following expiration of the rule suspension.

SECTION 8. Section Ins 9.32 (2) (a) is amended to read:

Ins 9.32 (2) (a) Provide covered benefits by participating providers with reasonable promptness ~~with respect to geographic location, hours of operation, waiting times for appointments in provider offices and after hours care. The hours of operation, waiting times, and availability of after hours care shall reflect the usual practice in the local area.~~ consistent with normal practices and standards in the geographic 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.

SECTION 9. Section Ins 9.32 (2) (f) is repealed.

SECTION 10. Section Ins 9.32 (2) (fm) is created to read:

Ins 9.32 (2) (fm) Provide emergency medical services as a covered benefit when the enrollee receives treatment for an emergency medical condition, as defined by s. 632.85, Stats., from a nonparticipating provider. The insurer shall cover the treatment of the emergency medical condition rendered by a nonparticipating provider as though the services were rendered 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. The insurer shall compensate the nonparticipating providers at the rate the insurer pays nonparticipating providers and after applying any co-payments, coinsurance, deductibles or other cost-sharing provisions that apply to participating providers until the nonparticipating provider has met its obligations under 42 U.S.C. §1395dd.

NOTE: The commissioner intends to enforce this section following expiration of the rule suspension.

SECTION 11. Sections Ins 9.41 and 9.42 (1) and (5) (a) are amended to read:

Ins 9.41 **Right of the commissioner to request OCI complaints be handled as grievances.** An insurer offering a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization shall treat and process an OCI complaint as a grievance at the request of the commissioner. The commissioner will provide a written description of the OCI complaint to the insurer.

Ins 9.42 **Compliance program requirements.** (1) All insurers offering a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization except to the extent otherwise exempted under this chapter or by statute, are responsible for compliance with ss. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36 and 632.83, Stats., applicable sections of this subchapter and other applicable sections including but not limited to s. Ins 9.07. Insurers offering a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization, to the extent they are required to comply with those provisions, shall establish a compliance program and procedures to verify compliance. Nothing in this section shall affect the availability of the privilege established under s. 146.38, Stats.

(5) (a) Any audits, and associated work papers of audits, conducted during the period of review relating to the business and service operation of the insurer offering a defined network ~~or limited scope~~ plan, preferred provider plan or limited service health organization.

SECTION 12. Enforcement. This rule may be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats. The changes in sections 1 – 6, 8-9, 11-12 of this proposed rule will be enforced immediately following the effective date of the rule (revisor inserts date).

The changes in sections 7 and 10 of this proposed rule will be enforced by the commissioner following expiration of the rule suspension.

SECTION 13. Applicability date. This rule shall first apply to newly issued policies or certificates of insurance on or after January 1, 2007, and to policies renewed on or after January 1, 2008, except for sections 7 and 10 which first apply following the expiration of the rule suspension.

SECTION ~~13~~14. Effective date. The changes to sections 7 and 10 of this proposed rule first take effect following the expiration of the rule suspension (revisor inserts date). ~~These~~The remainder of the changes take effect on the first day of the month after publication, as provided in s. 227.22(2)(intro.), Stats.

Dated at Madison, Wisconsin, this _____ day of _____, 2006.

_____

Jorge Gomez
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

This rule change will have no significant effect on the private sector regulated by OCI.

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **Ch. INS 9**

Subject

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	**Annualized Fiscal impact on State funds from:**	
A. State Costs by Category	**Increased Costs**	**Decreased Costs**
State Operations - Salaries and Fringes	**$ 0**	**$ -0**
(FTE Position Changes)	(**0** FTE)	(**-0** FTE)
State Operations - Other Costs	**0**	**-0**
Local Assistance	**0**	**-0**
Aids to Individuals or Organizations	**0**	**-0**
TOTAL State Costs by Category	**$ 0**	**$ -0**
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	**$ 0**	**$ -0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	**$ 0**	**$ -0**
GPR Earned	**0**	**-0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
TOTAL State Revenues	**$ 0 None**	**$ -0 None**

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ **None 0**	$ **None 0**
NET CHANGE IN REVENUES	$ **None 0**	$ **None 0**

Prepared by:	**Telephone No.**	**Agency**
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date**

Division of Executive Budget and Finance
DOA-2048 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **Ch INS 9**

Subject

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues

☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues

☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others _____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected ☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date**