LCRC
FORM 2

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Ronald Sklansky
Clearinghouse Director

Richard Sweet
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CLEARINGHOUSE REPORT TO AGENCY

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

CLEARINGHOUSE RULE **02-069**

AN ORDER to renumber Ins 9.01 (4) to (11); to renumber and amend Ins 9.01 (6) and (12); to amend Ins 9.01 (3), (13), (15) and (17) (intro.) and (a), 9.07, subchapter III (title) of chapter Ins 9, 9.30, 9.31, 9.32 (1) and (2) (intro.) and (a) and (d), 9.34 (1) and (2), 9.35, 9.36, 9.37, 9.38 (intro.) and (4), 9.39 (4), 9.40 and 9.42; and to create Ins 9.33, relating to revising requirements for defined network plans, preferred provider plans and limited service health organization plans to comply with recent changes in state laws.

Submitted by **OFFICE OF COMMISSIONER OF INSURANCE**

05-15-2002 RECEIVED BY LEGISLATIVE COUNCIL.

06-13-2002 REPORT SENT TO AGENCY.

RS:JLK

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LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

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

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

   Comment Attached YES ☑ NO ☐

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

   Comment Attached YES ☑ NO ☐

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

   Comment Attached YES ☑ NO ☐

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

   Comment Attached YES ☑ NO ☐

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

   Comment Attached YES ☑ NO ☐

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

   Comment Attached YES ☐ NO ☑

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

   Comment Attached YES ☐ NO ☑

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CLEARINGHOUSE RULE 02-069

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated September 1998.]

1. Statutory Authority

a. The definition of a preferred provider plan is in s. 609.01 (4), Stats. Section 609.35, Stats., as created by 2001 Wisconsin Act 16, indicates that a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to certain statutory requirements.

Section Ins 9.01 (15) defines preferred provider plan. In addition to cross-referencing the statutory definition in s. 609.01 (4), Stats., s. Ins 9.01 (15) requires that an insurer offering a preferred provider plan cover the same services both in-plan and out-of-plan without material disincentives and describes coverage requirements for out-of-plan provider services. Section Ins 9.01 (15) indicates that a preferred provider plan must comply with all of the provisions in s. Ins 9.01 (15) and may not identify a product as a preferred provider plan unless it does so.

However, the statutes do not require that a preferred provider plan cover the same services both in-plan and out-of-plan without material disincentives in order to be defined as a preferred provider plan. To the contrary, the statutes only appear to specify that a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to certain statutory requirements relating to adequate choice of providers, primary provider selection, specialist providers, telephone access, development of comprehensive quality assurance standards, and appointment of a physician as medical director. The definition of "preferred provider plan" in s. Ins 9.01 (15) should reflect the statutory definition in s. 609.01

(4), Stats., rather than imposing additional provisions. (Also, see the comment 2. g. regarding the inclusion of substantive provisions in a definition.)

b. Section 609.35, Stats., provides that a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to certain statutory requirements as cited above. Section Ins 9.33 provides that insurers that offer "different" coverage ***or*** coverage that is "more" [sic] (see the last sentence of s. Ins 9.33 (1)) than 70% of usual and customary fees or that have other certain provisions must comply with the statutes and regulations as defined networks plans. (See comments below regarding whether this should have referred to "less," rather than "more," and whether this last provision should have referred to "defined network plans that are not preferred provider plans," rather than "defined network plans.")

While s. 609.35, Stats., refers to "covering" the same services, it does not require that the level of benefits for the covered services be the same regardless of whether the service is by a participating provider or nonparticipating provider. For example, the statute does not specify that there cannot be a different deductible or coinsurance provision if the service is performed by a nonparticipating provider rather than a participating provider or that the reimbursement rates to the providers must be the same.

Section Ins 9.33 does not differentiate between coverage and benefits. In contrast to the statute, s. Ins 9.33 (1) requires that coverage for out-of-network provider services be substantial, including not less than 70% of usual and customary fees, and s. Ins 9.33 (2) imposes additional provisions if benefits are significantly limited for out-of-network services. It does not appear that there is statutory authority for these provisions.

However, there is also a problem in the opposite direction. Section Ins 9.33 (2) provides that preferred provider plans that contain "material exclusions" uniquely applied to out-of-network provider services must comply with statutes and regulations as defined network plans. Since exclusions relate to coverage and since s. 609.35, Stats., refers to covering the "same" services, then any exclusion uniquely applied to out-of-service plans would trigger the provision in s. 609.35, Stats. Therefore, "exclusions" should not be modified by the word "material."

c. Section Ins 9.40 (2) requires that by April 1, 2007, a preferred provider plan must submit a quality assurance plan consistent with the requirements of s. 609.32, Stats. Preferred provider plans are generally subject to s. 609.32 (1m) and (2), Stats., but neither of these statutory provisions require the development of a quality assurance plan. The rule could make this clearer.

A preferred provider plan is subject to s. 609.32 (1), Stats., only if the preferred provider plan fails to cover the same services when performed by a nonparticipating provider that it covers when those services are covered by a participating provider, the preferred provider. [s. 609.35, Stats.] Thus, a quality assurance plan would be prepared by a preferred provider plan only in limited circumstances. If a preferred provider plan were subject to the requirement in s. 609.32 (1), Stats., because of a difference in covered services it is not clear that the commissioner has statutory authority to delay application until April 1, 2007.

d. The definition of "preferred provider plan" in s. 609.01 (4), Stats., includes the requirement that the plan offer health care services without referral. Sections Ins 9.01 (15) (a) and 9.33 (3) appear to define all pre-authorization requirements as referrals. It is not clear that this is comprehended under the statutes.

2. Form, Style and Placement in Administrative Code

a. In SECTION 1, the title of the chapter should be shown in solid capital letters. [s. 1.05 (2) (a), Manual.] In addition, the reference to "Subchapter I: Definitions" should not be included as it is not being amended.

b. The colon following SECTION 2 should be changed to a period. This comment also applies to SECTION 12. Also, in SECTION 2, the period following "Ins" should be deleted. Finally, it is not necessary to include the word "Section" in the treatment clause. [s. 1.04 (a), Manual.] The last comment applies throughout the rule.

c. The treatment clause in SECTION 5 should be amended to read "Ins 9.01 (12), is renumbered Ins 9.01 (4) and is amended to read:".

d. In s. Ins 9.01 (4), the definition of "defined network plan," as distinguished from "managed care plan," deletes the inclusion of "Medicare + Choice plan" as defined in s. Ins 3.39 (3) (cm). References to the Medicare + Choice plan are also deleted in ss. Ins 9.35 (4) and 9.39 (4). If these deletions are a substantive change, they should be noted or explained in the analysis. [s. 1.02 (2), Manual.]

e. The treatment clause of SECTION 6 should be changed to refer to "Ins 9.01 (13), (15), and (17) (intro.), (a), and (c)".

f. Section Ins 9.01 (13) defines "OCI complaint." However, that defined term is not used in ch. Ins 9. Therefore, the definition should be deleted. If the material in the definition is inserted elsewhere in ch. Ins 9, it should be explained in the analysis.

g. Section Ins 9.01 (15) includes extensive substantive provisions with which preferred provider plans must comply and prohibits use of the term preferred provider plan unless there is compliance. Such substantive provisions may not be included in the definition. [s. 1.01 (7) (b), Manual.] Moreover, it appears that many of these substantive provisions are included in s. Ins 9.33. Section Ins 9.01 (15) should read: "'Preferred provider plan' has the meaning given in s. 609.01 (4), Stats."

h. In s. Ins 9.01 (15) (a), the first sentence uses the phrase "shall not." The correct way to express this prohibition is "may not." [s. 1.01 (2), Manual.] In addition, various provisions in the rule refer to "must" rather than "shall." For example, see ss. Ins 9.01 (15) (b) and 9.33 (1) and (2). The correct way to denote a mandatory or absolute duty or directive is by using the word "shall." [s. 1.01 (2), Manual.] The entire rule should be reviewed for this problem.

i. In SECTION 7, the treatment clause should indicate that "Ins 9.07 (1) is amended to read:".

j. In SECTION 8, the treatment clause should indicate that "Subchapter III (title) of chapter Ins 9 is amended to read:". In addition, the text of SECTION 8 should show the title in capital letters. [s. 1.05 (2) (a), Manual.]

k. The treatment clause in SECTION 10 should be revised to read: "Ins 9.32 (1) and (2) (intro.), (a), and (d) are amended to read:".

l. The title of s. Ins 9.33 should be shown in bold print. [s. 1.05 (2) (b), Manual.] Also, it should be followed by a period. Also, the title of s. Ins 9.33 (1) should be shown in solid capital letters. [s. 1.05 (2) (c), Manual.] However, a title should not be included for s. Ins 9.33 (1) unless a title also is included for s. Ins 9.33 (2) and (3). [s. 1.05 (1), Manual.]

m. SECTION 11 creates s. Ins 9.33. Therefore, the material in s. Ins 9.33 should not be underscored inasmuch as it is not an amended provision. [s. 1.06 (1), Manual.] The entire rule should be reviewed for occurrences of this error and the error of repealing an entire rule unit by overstriking it.

n. In s. Ins 9.34, the title should be followed by a period. Also, in s. Ins 9.34 (1), it appears that the intention was to insert "(a)" following the title "ANNUAL CERTIFICATION." Otherwise, the print type for the title is inaccurate, and titles would be required for all of the paragraphs in that subsection. A similar comment applies to s. Ins 9.34 (2).

o. In s. Ins 9.34 (1) (b), the reference to "filed within three months of the effective date of this rule" should be changed to "filed within three months of the effective date of this paragraph .... [revisor inserts date]". [ss. 1.01 (9) (b) and 1.07 (1) (a), Manual.]

p. Section Ins 9.34 (1) (b) refers to a form prescribed by the commissioner. A copy of the form must be attached to the rule or a statement must be included indicating where a copy of the form may be obtained at no charge. A Note must be included about the form, including describing the address and telephone number to be used to obtain the form. Also, if the form is available on the Internet, the Note should indicate the web site from which the form may be obtained. [s. 1.09 (2), Manual.]

q. Section Ins 9.34 (2) (a) (intro.) provides introductory material to s. Ins 9.34 (2) (a) 1., 2., and 3. It should explain the relationship of these subdivisions to the introduction by use of a phrase such as "shall have the capability to do all of the following:". [s. 1.03 (8), Manual.] A similar comment applies to ss. Ins 9.34 (2) (b) (intro.), 9.40 (7) (intro.), and 9.42 (2) (intro.) and (4) (intro.).

r. In s. Ins 9.35 (1m), "subs. 1 (a) or (b)" should be changed to "sub. (1) (a) or (b)". [s. 1.07 (2), Manual.] In the last sentence, the phrase "is responsible for enforcing the contract and ensuring" should be replaced by the phrase "shall enforce the contract and ensure."

s. In the treatment clause of SECTION 14, "9.38 (4)" should be changed to "9.38 (4) (intro.) and (c)".

t. In the deleted portion of s. Ins 9.40 (3) (c) 1., "~~defined network~~" should be deleted. [s. 1.06 (1), Manual.]

u. In s. Ins 9.42 (1), the reference to "exempted under this rule" should be changed to specify a reference. [s. 1.07 (1) (a), Manual.]

v. SECTION 17 indicates that "Section Ins 9.42 is amended to read:". However, various subsections in s. Ins 9.42 are neither amended nor reprinted in the text in their current form. The treatment clause of SECTION 17 should indicate specifically which subsections and paragraphs are amended, with changes shown only for those subsections and paragraphs.

3. Conflict With or Duplication of Existing Rules

It appears that the proposed order also should change other references to managed care plans in the administrative code. For example, consideration should be given to changing references to managed care plans in ss. Ins 3.67 and 18.03 (2) (c) 1.

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

a. The "statutory authority" section does not refer to s. 609.20, Stats. Was this omission intentional?

b. Section Ins 9.34 (1) (b) requires an insurer to certify compliance with s. Ins 9.32 for the preceding year. Section Ins 9.32 provides limited exemptions. Is this the correct cross-reference? Also, is it correct that an insurer must certify compliance with s. 609.22 (4), Stats.? Under s. 609.35, Stats., s. 609.22 (4), Stats., does not apply unless the preferred provider plan does not cover the same services when performed by nonparticipating providers as participating providers. Finally, the notation "ss." should be replaced by the notation "s."

c. Section Ins 9.42 (9) requires that a preferred provider plan that is not also a defined network plan comply with "this section" to the extent applicable. If the other subsections already made clear if they were applicable, this subsection would not be necessary. If the other subsections did not make clear if they were applicable, this subsection should either be changed or eliminated as it provides no new information.

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

a. The second paragraph of the analysis confusingly indicates that ch. Ins 9 differentiates between preferred provider plans that "may or may also be" defined network plans. The statutes differentiate between defined network plans that are preferred provider plans and defined network plans that are not preferred provider plans. [See ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), Stats.] Some preferred provider plans that are defined network plans are treated differently for some purposes than other defined network plans, namely when the preferred provider plan does not cover the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider. [s. 609.35, Stats.] Should the first clause of the second sentence in the second paragraph of the analysis refer to preferred provider plans eligible for distinct treatment from "other" defined network plans, rather than distinct treatment from defined network plans?

b. In the last sentence of the next-to-last paragraph of the analysis, "assume" should be changed to "assumes."

c. In s. Ins 9.01 (3), it is not clear what is meant by "indirect contract." A similar comment applies to s. Ins 9.01 (4). Is this a subcontract? If so, ambiguity could be avoided by referring to subcontracts as in s. Ins 9.07.

d. In SECTION 4, it is not necessary to show the subsection number as "(~~5~~6)," inasmuch as s. Ins 9.01 (6) has already been renumbered in SECTION 3. The entry in SECTION 4 could be shown simply as "(6)." A similar comment applies to SECTION 5.

e. In the first sentence of s. Ins 9.01 (15) (a), it appears that "preferred provider plan provides" should be changed to "preferred provider plan that provides". Otherwise, the sentence has two verbs.

f. In s. Ins 9.01 (15) (a), would the last sentence be clearer if it indicated that the pre-authorization is used by the plan "only for utilization management or incentives"?

g. Section Ins 9.01 (15) (b) refers to "usual and customary rates." However, s. Ins 9.33 (1) refers to "usual and customary fees." If a distinction is not intended, one term should be selected and used consistently in order to avoid ambiguity.

h. Both ss. Ins 9.01 (15) (b) and 9.33 (2) refer to "material" exclusions, deductibles, maximum limits, or other conditions. It appears that the word "material" applies to all of these words, rather than the term "exclusion" only; however, there is some ambiguity because both interpretations are possible. Moreover, it is not clear how a determination is made as to what "material" means in these provisions or in the reference to "material" disincentives in s. Ins 9.01 (15) (b). Also, how is it determined that benefits are "significantly" limited in s. Ins 9.33 (2)?

i. In s. Ins 9.07 (1), the reference to insurers offering a defined network plan, preferred provider plan, ***and*** limited service health organization plan should be changed to refer to insurers offering a defined network plan, preferred provider plan, ***or*** limited service health organization plan. Otherwise, the provision would apply only to an insurer that offers all three types of plans and not to an insurer that offered some, but not all, of these plans. This comment also appears to apply to ss. Ins 9.30 and 9.42 (1).

j. In s. Ins 9.07 (1), the provision requiring that insurers make available to the commissioner "all executed copies of any provider agreements between the insurer and subcontracts with individual practice associations or individual providers" is confusing because it does not specify who the "between" applies to in addition to the insurer. Is it intended to refer to provider agreements or subcontracts between the insurer and individual practice associations or individual providers? If so, this should be clarified.

k. In s. Ins 9.07 (1), the last sentence contains several errors. First, "contain" should be changed to "~~contain~~ contains" because the subject is "portion." Second, the last part of the sentence is confusing because it indicates that the commissioner may withhold that portion of the contract containing trade secrets from the "insurer." Since it was the insurer who disclosed the agreement to the commissioner, this provision seems nonsensical. Is the intent to indicate that the commissioner may refuse to disclose that portion of the contract to a person who requests disclosure to the extent that it may be withheld under s. Ins 6.13? If so, this should be clarified.

l. Section Ins 9.31 refers to insurers "providing" various plans, whereas other provisions in ch. Ins 9 refer to insurers "offering" various plans. Was the reference in the first sentence of s. Ins 9.31 intentionally applying only to insurers "providing" these plans, as opposed to "offering" these plans? Also, s. Ins 9.32 (2) (intro.), refers to insurers "writing" plans. Unless a distinction is intended, consistent use of one term would help avoid ambiguity.

m. The second sentence of s. Ins 9.33 (1) requires that the coverage of out-of-network providers be 70% or more of usual and customary fees. The last sentence requires that insurers that offer different coverage or coverage at more than 70% of usual and customary fees comply with statutes and regulations as defined network plans. If the coverage were at exactly 70% of usual and customary fees, was the intention that the last sentence not apply even though the second sentence would apply? Also is the 70% referring to reimbursement to the providers, a coinsurance provision, or coverage to which a deductible and coinsurance provision may then be applied?

Also, it appears that the last sentence should refer to coverage at ***less*** than 70% of usual and customary fees, rather than ***more*** than 70%.

In addition, what is meant by "different" coverage in s. Ins 9.33 (1)? If "different" is intended to be explained in s. Ins 9.33 (2), this should be specified.

n. In s. Ins 9.33 (1), was the last sentence intended to refer to complying with statutes and regulations as defined network plans that are not preferred provider plans? (See comment a., above.) This comment also applies to s. Ins 9.33 (2) and (3). Also, "regulations" is not an appropriate term, and it would be preferable to cite any applicable statutes and rules.

o. There is inconsistent hyphenation with respect to "in-network" and "out of network" in s. Ins 9.33 (1) and (2). Was the difference intended? Also, is there a substantive difference between "out-of-plan" in s. Ins 9.01 (15) (b) and "out of network" in s. Ins 9.33 (1) and (2)? If not, a term should be selected and used consistently to avoid ambiguity. Also, hyphenation should be used consistently throughout the rule.

p. Consideration should be given to revising s. Ins 9.33 (3) to make it more understandable. For example, it appears that there are only two items in the series in the first clause, that is, referral requirements and incentives. If so, they should be separated by a conjunction, such as "or," rather than a comma. Also, it would be useful to set off the "including" clause by preceding it with a comma. The word "would" should be eliminated in order to make an affirmative statement that such a plan is disqualified. In addition, the phrase "and the plan shall then be subject to the requirements of defined network plans" should be drafted as a separate sentence.

q. In s. Ins 9.34 (2) (a) 1. and (b) 1., "after hour care" should be changed to "after hours care."

r. With regard to s. Ins 9.35 (1), it appears that with the creation of s. Ins 9.35 (1m), the application of s. Ins 9.35 (1) should be limited to defined network plans that are not preferred provider plans.

s. Section Ins 9.35 (1) (a) requires the plan to identify terminated providers in a separate section in the annual provider directory. It does not make clear how long a terminated provider must be included in the annual provider directory. Is it for only the directory following the year of termination? This could be specified to avoid ambiguity.

t. Section Ins 9.35 (1) (a) (intro.) should indicate that "the plan shall comply with all of the following as appropriate".

u. Section Ins 9.35 (1) (a) 1. and 2. both require notice to an enrollee of termination "the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the termination notice." It appears that it would be more appropriate to phrase this as requiring that the notice be sent no later than 30 days prior to the date of termination or 15 days following the date the insurer received the termination notice, whichever is later. Section Ins 9.35 (1) (a) 3. should be reviewed for a similar problem. Also, s. Ins 9.35 (1) (a) 3. requires a provider to post a notification of termination with the plan in the provider's office by a certain date. It does not specify how long the notification must be posted. For example, is removal after a month permitted?

v. In s. Ins 9.37 (4), the semicolon in the first sentence should be changed to a comma.

w. In s. Ins 9.40 (3) (intro.), additional language is needed at the beginning to make a complete sentence inasmuch as there is no s. Ins 9.40 (intro.). As currently drafted, there is no clear statement as to which insurers the requirements in s. Ins 9.40 (3) apply to.

x. In s. Ins 9.40 (3) (b), "Written plan" should be changed to "A written plan".

y. In s. Ins 9.40 (3) (c), use of the word "plan" is confusing inasmuch as an insurer is required to develop a remedial action plan containing various elements, and s. Ins 9.40 (3) (c) requires that certain functions be performed by the "plan." Would it be more accurate to indicate that the management functions are to be performed by the insurer?

z. In s. Ins 9.40 (3) (e), the two "including" clauses, neither of which is set off by punctuation, are confusing. Consideration should be given to revising this paragraph, for example, by preceding the first "including" clause with a comma and by moving the information in the second "including" clause to a separate sentence.

aa. In s. Ins 9.40 (3) (g), the word "A" should be inserted at the beginning of the sentence.

bb. In s. Ins 9.40 (3) (h), it may be useful to list the items in the second sentence as subdivision paragraphs with an introductory clause, such as "Documentation shall include all of the following:". If this is not done, a semicolon is needed preceding the last conjunction. Also, should "outcome of the plan" be changed to "outcome of the issue"? If not, how is the outcome of the remedial action plan determined? Finally, the phrase "a issue" should be replaced by the phrase "an issue."

cc. In s. Ins 9.42 (3) and (4) (intro.), it appears that the last conjunction in the series of statutes should be "or" rather than "and". If so, the notation "ss." should be replaced by the notation "s." (However, the references in s. Ins 9.42 (4) (a) and (e) appear to accurately refer to "and".)

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott McCallum, Governor
Connie L. O'Connell, Commissioner

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TO: Ron Sklansky, Director, Legislative Council
1 East Main Street, Suite 401, Madison, WI 53701

FROM: Fred Nepple, General Counsel
Office of the Commissioner of Insurance

DATE: May 15, 2002

SUBJECT: Ch. Ins 9, Wis. Adm. Code, relating to Defined Network Plans

NOTICE OF SUBMITTAL TO LEGISLATIVE COUNCIL STAFF

Rule Submittal Date

In accordance with ss. 227.14 and 227.15, Stats., the Office of the Commissioner of Insurance is submitting a proposed rule to the Wisconsin Legislative Council Rules Clearinghouse on May 15, 2002.

Analysis

These changes will affect Section Ins Ch. Ins 9, Wis. Adm. Code, relating to Defined Network Plans.

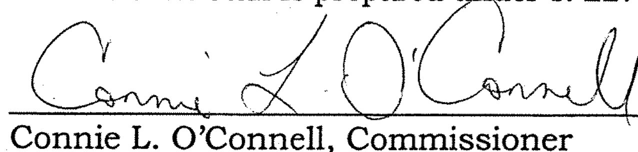
Agency Procedure for Promulgation

The date for the public hearing is June 19, 2002.

Contact Person

A copy of the proposed rule may be obtained from the OCI internet WEB site at **http://www.state.wi.us/agencies/oci/ocirules.htm** or by contacting Inger Williams, Services Section, Office of the Commissioner of Insurance, at (608) 264-8110. For additional information, please contact Julie E. Walsh at (608) 264-8101 or e-mail at Julie.Walsh@oci.state.wi.us in the OCI Legal Unit.

This Notice of Submittal to Legislative Council Staff is prepared under s. 227.135, Stats., and approved on May 14, 2002.



Connie L. O'Connell, Commissioner

FN:JW
Attachment: 1 copy rule

★★★ NOTICE OF RULEMAKING HEARING ★★★

NOTICE IS HEREBY GIVEN that pursuant to the authority granted under s. 601.41(3), Stats., and the procedure set forth in under s. 227.18, Stats., OCI will hold a public hearing to consider the adoption of the attached proposed rulemaking order affecting Section Ins Ch Ins 9, Wis. Adm. Code, relating to Defined Network Plans.

HEARING INFORMATION

Date: **June 19, 2002**
Time: **10:00 a.m., or as soon thereafter as the matter may be reached**
Place: **Room 6, OCI, 121 East Wilson Street, Madison, WI**

Written comments on the proposed rule will be accepted into the record and receive the same consideration as testimony presented at the hearing if they are received at OCI within 14 days following the date of the hearing. Written comments should be addressed to: Julie E. Walsh, OCI, PO Box 7873, Madison WI 53707

SUMMARY OF PROPOSED RULE & FISCAL ESTIMATE

For a summary of the rule see the analysis contained in the attached proposed rulemaking order. There will be no state or local government fiscal effect. The full text of the proposed changes and the fiscal estimate are attached to this Notice of Hearing.

INITIAL REGULATORY FLEXIBILITY ANALYSIS

This rule does not impose any additional requirements on small businesses.

CONTACT PERSON

A copy of the full text of the proposed rule changes and fiscal estimate may be obtained from the OCI internet WEB site at **http://www.state.wi.us/agencies/oci/ocirules.htm** or by contacting Inger Williams, Services Section, Office of the Commissioner of Insurance, at (608) 264-8110 or at 121 East Wilson Street, PO Box 7873, Madison WI 53707-7873.

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING, RENUMBERING, RENUMBERING AND AMENDING, AMENDING, REPEALING AND CREATING AND CREATING A RULE AMENDING A RULE

To renumber Ins. 9.01(4) to (11); to renumber and amend Ins 9.01 (6) and 9.01(12); to amend Ins 9.01(3), 9.01(13), 9.01(15), 9.01(17), 9.01(17)(a), 9.07, subchpt. III (title), 9.30, 9.31, 9.32(1), 9.32(2), 9.32(2)(a), 9.32(2)(d), 9.34(1), 9.34(2), 9.35, 9.36, 9.37, 9.38 (intro), 9.38(4), 9.39 94), 9.40, 9.42; and to create Ins 9.33, Wis. Adm. Code, relating to revising requirements for defined network plans, preferred provider plans and limited service health organization plans to comply with recent changes in state laws.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 609.38, and 632.85, Stats.
Statutes interpreted: ch. 609 and s. 632.85, Stats.

Most of the revisions are based on a terminology change in how managed care plans are to be referred to as defined network plans as established in 2001 Wisconsin Act 16. In addition, the 2001 Wisconsin Act 16 modified some requirements of ch. 609, Stats., as they apply to preferred provider plans, and those changes are reflected accordingly within ch. Ins 9.

Chapter Ins 9 differentiates between preferred provider plans that may or may also be defined network plans. For a preferred provider plan to be eligible for distinct treatment from defined network plans, the insurer offering the plan must provide the covered services without requirement of a referral including pre-authorization even if such pre-authorization is used by the plan for utilization management or use of

incentives. The insurer offering a preferred provider plan must comply with s. 609.35, Stats., and cover the same services both in-plan and out-of-plan without material disincentives. The coverage must be substantial with coverage not less than 70% of usual and customary rates and no material exclusions, deductibles, maximum limits or other conditions uniquely applied to out-of-plan provider services resulting in significantly limited out of plan benefits.

In addition, the insurer offering preferred provider plans must have participating plan providers who are accepting patients within a reasonable distance of the insured and provide an adequate number of participating providers in each geographic area to service all insureds in that area. Preferred provider plans will need to provide telephone access for emergency care or authorization of care 24 hours per day. Whenever a participating provider's participation with the plan terminates, the preferred provider plan must directly or by contract notify the insureds. However, if the insurer contracts for the notification of provider termination, the insurer remains responsible for ensuring that notification is sent.

If a plan qualifies as a preferred provider plan, the plan would no longer be required to develop quality assurance standards relating to access to, and continuity and quality of care. However, the insurer would still be responsible for developing procedures for remedial action to address quality problems in each of these areas. Also, a preferred provider plan that assume direct responsibility for clinical protocols and utilization management of the plan would be required to appoint a physician as a medical director.

Insurers offering preferred provider plans that contain material exclusions, deductibles, maximum limits or other conditions uniquely applied to out of network provider services resulting in significantly limited out of network benefits must comply with statutes and regulations as a defined network plan.

SECTION 1. Chapter Ins 9 (title) is amended to read:

CHAPTER INS 9

~~Managed Care~~Defined Network Plans
Subchapter I: Definitions

Section 2: Section Ins 9.01 (3) is amended to read:

Ins. 9.01 (3) "Complaint" means any expression of dissatisfaction expressed ~~about an~~to the insurer ~~or its contracted providers expressed~~by an enrollee, or an enrollee's authorized representative, ~~to the insurer~~about an insurer or its providers with whom the insurer has a direct or indirect contract.

Section 3. Sections Ins 9.01 (4) to (11) are renumbered to Ins 9.01 (5) to (12).

Section 4. Section Ins 9.01 (6), as renumbered, is amended to read:

(~~5~~6) "Grievance" means any dissatisfaction with the ~~administration,~~ provision of services or claims practices ~~or provision of services by a~~ ~~managed care~~of an insurer offering a defined network plan, limited service health organization or preferred provider plan or administration of a defined network plan, limited service health organization or preferred provider plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an enrollee.

Section 5. Section Ins 9.01 (12)~~, before renumbering~~, is renumbered to Ins 9.01 (4) and amended to read:

(~~12~~4) "~~Managed care~~Defined network plan" has the meaning provided under s. 609.01 (~~3c~~1b), Stats., and includes ~~Medicare + Choice plan as defined in s. Ins 3.39 (3) (cm),~~ Medicare Select policy as defined in s. Ins 3.39 (30) (b) 4., and health benefit plans that either directly or indirectly contract for use of providers.

Section 6. Sections Ins 9.01 (13), (15), (17), (17)(a) and (17)(c) are amended to read:

(13) "OCI complaint" means any ~~written~~ complaint received by the Office of the Commissioner of Insurance by, or on behalf of, an enrollee of ~~a managed care~~ an insurer offering a defined network plan, preferred provider plan or limited service health organization.

(15) "Preferred provider plan" has the meaning provided under s. 609.01 (4), Stats., and must comply with all of the following. Only insurers offering products meeting the definition, including the following, may identify that product as a preferred provider plan in its name or description to consumers:

(a) The insurer offering a preferred provider plan provides the covered services shall not require referrals. For purposes of this chapter, referrals include pre-authorization even if such pre-authorization is used by the plan for utilization management or use of incentives.

(b) The insurer offering a preferred provider plan must comply with s. 609.35, Stats., and cover the same services both in-plan and out-of-plan without material disincentives. The coverage must be substantial with coverage not less than 70% of usual and customary rates and no material exclusions, deductibles, maximum limits

or other conditions uniquely applied to out-of-plan provider services resulting in significantly limited out of plan benefits.

(17) "Silent provider network" means one or more participating providers that provide services covered under a ~~managed care~~defined network plan where all of the following apply:

(a) The insurer does not include any incentives or penalties in the ~~managed care~~defined network plan related to utilization or failure to utilize the provider.

(c) The insurer, in any arrangement described under par. (b), requires that the reduction in fees will be applied with respect to cost sharing portions of expenses incurred under the ~~managed care~~defined network plan to the extent the provider submits the claim directly to the insurer.

Section 7. Section Ins 9.07 is amended to read:

Ins 9.07 Copies of provider agreements. **(1)** Notwithstanding any claim of trade secret or proprietary information, all ~~managed care~~insurers offering a defined network plan, preferred provider plan ~~insurers~~ and limited service health organization ~~insurers~~ plan shall, upon request, make available to the commissioner all executed copies of any provider agreements between the insurer and subcontracts with individual practice associations or individual providers. ~~Managed care~~Insurers offering defined network plans, preferred provider plans, limited service health organizations, provider networks or independent practice associations may assert that a portion of the contracts contain trade secrets and the commissioner may withhold that portion from the insurer to the extent it may be withheld under s. Ins. 6.13.

Section 8. Subchapter III Ins 9 (Title) is amended to read:

Subchapter III: Market Conduct Standards for ~~Managed Care~~Defined Network Plans.

Section 9. Sections Ins 9.30 and 9.31 are amended to read:

Ins 9.30 Purpose. This subchapter establishes market conduct standards for insurers offering ~~managed care~~defined network plans, preferred provider plans and limited service health organizations doing business in Wisconsin. These requirements are in addition to any other statutory or administrative rule requirements that apply to insurers offering ~~managed care~~defined network plans, preferred provider plans or limited service health organizations.

Ins 9.31 Scope. This subchapter applies to all insurers providing ~~managed care~~defined network plans, preferred provider plans or limited service health organization plans in this state. The insurer shall ensure that the requirements of this subchapter are met by all ~~managed care~~defined network plans, preferred provider plans or limited service health organization plans issued by the insurer. The commissioner may approve an exemption to this subchapter for an insurer to market a ~~managed care~~defined network plan, preferred provider plan or limited service health

organization plan if the plan is filed with the commissioner and the commissioner determines that all of the following conditions are met:

Section 10. Sections Ins 9.32 (1), (2), (2)(a) and (2)(d) are amended to read:

Ins 9.32 Limited exemptions. (1) SILENT DISCOUNT. An insurer, with respect to a ~~managed care~~defined network plan:

(2) DE MINIMUS LIMITED EXCEPTION. Insurers writing ~~managed care~~defined network plans are exempt from meeting the requirements under ss. 609.22 (1) to (4) and (8), 609.32 and 609.34, Stats., ss. Ins 9.34 (2) (a) and (b), 9.40 (1) to (7), and 9.42 (6) and (7), with respect to a ~~managed care~~defined network plan, if the insurer meets all of the following requirements.

(a) The ~~managed care~~defined network plan provides comprehensive benefits to insureds of at least 80% coverage for in-plan providers.

(d) The insurer makes no representation that the ~~managed care~~defined network plan is a preferred provider plan or that the plan directs or is responsible for the quality of health care services. Nothing in this paragraph prevents an insurer from describing the availability or limits on availability of participating providers or the extent or limits of coverage under the ~~managed care~~defined network plan if participating or non-participating providers are utilized by an insured.

Section 11. Section Ins 9.33 is created to read:

Ins 9.33 Preferred provider plans **(1)** Exceptions. Insurers offering preferred provider plans that meet the definition of s. 609.01 (4), Stats., and s. Ins 9.01 (15), must provide coverage for the same services when performed by a provider out of the network that the insurer covers by an in-network provider. Coverage for out of network provider services must be substantial, including not less than 70% of usual and customary fees. Insurers that offer different coverage or coverage at more than 70% of usual and customary fees must comply with statutes and regulations as defined network plans.

(2) Insurers offering preferred provider plans that contain material exclusions, deductibles, maximum limits or other conditions uniquely applied to out of network provider services resulting in significantly limited out of network benefits must comply with statutes and regulations as a defined network plan.

(3) Insurers offering preferred provider plans that require any referral requirements, incentives including financial, even if under the pretext of a utilization management process, such as pre-authorization requirements, would disqualify the plan from the definition of a preferred provider plan and the plan shall then be subject to the requirements of defined network plans.

Section 12: Sections Ins 9.34 (1) and (2) are amended to read:

Ins 9.34 Access standards (1)(a) ANNUAL CERTIFICATION. An insurer offering a ~~managed care~~defined network plan that is not a preferred provider plan shall file ~~a~~ an

annual certification with the commissioner ~~within 3 months after the effective date of this rule, and thereafter,~~ no later than August 1 of each year ~~shall submit an annual certification to the commissioner~~ demonstrating compliance with the access standards of this section and with s. 609.22, Stats., and s. Ins 9.32 for the preceding year. The certification shall be submitted on a form prescribed by the commissioner and signed by an officer of the company.

(b) An insurer offering a preferred provider plan shall, in its annual certification to the commissioner that is to be filed within 3 months of the effective date of this rule and thereafter, no later than August 1 of each year, on a form prescribed by the commissioner and signed by an officer of the company, certify compliance with ss. 609.22 (1), (4), (4m), (5), (6) and (8), Stats., and s. Ins 9.32 for the preceding year.

(2)(a) ADDITIONAL REQUIREMENTS. An insurer offering a ~~managed care~~defined network plan other than a preferred provider plan shall have the capability to:

~~(a)~~1. Provide covered benefits by plan providers with reasonable promptness and with respect to geographic location, hours of operation, waiting times for appointments in provider offices and after hour 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

~~d(b)~~2. Have sufficient number and type of plan providers to adequately deliver all covered services based on the demographics and health status of current and expected enrollees served by the plan.

~~(c)~~3. Provide 24-hour nationwide toll-free telephone access for its enrollees to the plan or to a participating provider for authorization of care that is covered by the plan.

(b) An insurer offering a preferred provider plan shall:

1. Provide covered benefits by plan providers with reasonable promptness and with respect to geographic location, hours of operation, waiting times for appointments in provider offices and after hour care. The hours of operation, waiting times, and availability of after hours care shall reflect the normal practice and standards in the local area and as appropriate to the type of plan. Geographic availability shall reflect the usual medical travel times within the community.

2. Have at least one participating provider, in addition to at least one primary provider, that is accessible, qualified and accepting new enrollees, with respect to covered benefits.

3. Provide telephone access to the plan or to a participating provider for emergency care or authorization for care for which coverage is provided under the plan.

Section 13. Section Ins 9.35, 9.36 and 9.37 are amended to read:

Ins 9.35 Continuity of care. **(1)** In addition to the requirements of s. 609.24, Stats., a ~~managed care~~defined network plan shall do ~~either~~ one of the following:

(a) Upon termination of a provider from a ~~managed care~~defined network plan, the plan shall appropriately notify all enrollees of the termination, provide information on substitute providers, and at least identify the terminated providers within a separate section of the annual provider directory. In addition, the plan shall comply with the following as appropriate:

1. If the terminating provider is a primary provider and the ~~managed care~~defined network plan requires enrollees to designate a primary provider, the plan shall notify each enrollee who designated the terminating provider of the termination the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice and shall describe each enrollee's options for receiving continued care from the terminated provider.

2. If the terminating provider is a specialist and the ~~managed care~~defined network plan requires a referral, the plan shall notify each enrollee authorized by referral to receive care from the specialist of the termination the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice and describe each enrollee's options for receiving continued care from the terminated provider.

3. If the terminating provider is a specialist and the ~~managed care~~defined network plan does not require a referral, the provider's contract with the plan shall comply with the requirements of s. 609.24, Stats., and require the provider to post a notification of termination with the plan in the provider's office the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice.

(b)1. Upon termination of a provider from a ~~managed care~~defined network plan, the plan shall notify all affected enrollees of the termination and each enrollee's options for receiving continued care from the terminated provider not later than 30 days prior to the termination, or upon notice by the provider if the plan receives less than 30 days notice. A ~~managed care~~defined network plan shall provide information on substitute providers to all affected enrollees.

2. If the provider is a primary provider and the ~~managed care~~defined network plan requires enrollees to designate a primary provider, the plan shall notify all enrollees who designated the terminating provider.

(1m) In addition to the requirements of s. 609.24, Stats., the insurer offering a preferred provider plan may either comply with subs. 1 (a) or (b) or may have a contract with participating providers requiring the provider to notify all plan enrollees of the enrollees' rights under s. 609.24, Stats., if the provider's participation terminates for reasons other than ~~provided in~~ sub. (2). The insurer offering the preferred provider plan is responsible for enforcing the contract and ensuring that enrollees are informed of a participating provider's termination.

(2) A ~~managed care~~defined network plan is not required to provide continued coverage for the services of a provider if either of the following are met:

(a) The provider no longer practices in the ~~managed care~~defined network plan's geographic service area.

(b) The insurer issuing the ~~managed care~~defined network plan terminates the provider's contract due to misconduct on the part of the provider.

(3) The ~~managed care~~defined network plan shall make available to the commissioner upon request all information needed to establish cause for termination of providers.

~~**(4)** Medicare + Choice plans are not subject to s. 609.24 (1) (e), Stats., in accordance with 42 USC 1395w-26 (3) (B) ii.~~

Ins 9.36 Gag clauses. (1) No contract between a ~~managed care~~defined network plan and a participating provider may limit the provider's ability to disclose information, to or on behalf of an enrollee, about the enrollee's medical condition.

(2) A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provider determines to be in the best interest of the enrollee and within the scope of the provider's professional license. A ~~managed care~~defined network plan may not penalize the participating provider nor terminate the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee. A ~~managed care~~defined network plan may not retaliate against a provider for advising an enrollee of treatment options that are not covered benefits under the plan.

Ins 9.37 Notice requirements. (1) PROVIDED INFORMATION. Prior to enrolling members, ~~managed care~~insurers offering defined network plans shall provide to prospective group or individual policyholders information on the plan including all of the following:

(2) PROVIDER DIRECTORIES. ~~Managed care~~Insurers offering defined network plans shall make current provider directories available to enrollees upon enrollment, and no less than annually, following the first year of enrollment.

(3) OBSTETRICIANS AND GYNECOLOGISTS. ~~Managed care~~Insurers offering defined network plans that permit obstetricians or gynecologists to serve as primary providers shall clearly so state in enrollment materials. ~~Managed care~~Insurers offering defined network plans that limit access to obstetricians and gynecologists shall clearly state in enrollment materials the process for obtaining referrals.

(4) STANDING REFERRAL CRITERIA. ~~Managed care~~Insurers offering defined network plans other than preferred provider plans shall make information available to their enrollees describing the criteria for obtaining a standing referral to a specialist, including under what circumstances and for what services a standing referral is available, how to request a standing referral; and how to appeal a standing referral

determination. For purposes of s. 609.22 (4), Stats., and this subsection, referral includes prior authorization for services regardless of use or designation of a primary care provider.

Section 14. Section Ins 9.38 (intro) and 9.38(4) are amended to read:

Ins 9.38 Policy and certificate language requirements. Each policy form marketed or each certificate issued to an enrollee by ~~a managed care~~an insurer offering a defined network plan or limited service health organization plan shall contain all of the following:

(4) DISCLOSURE OF PROCEDURES AND EMERGENCY CARE NOTIFICATION. ~~Managed care~~Insurers offering defined network plans shall do all of the following in a manner consistent with s. 609.22, Stats.:

(c) Consistent with s. 609.22 (6), Stats., ~~a managed care~~an insurer offering a defined network plan may require enrollees to notify the insurer of emergency room usage, but in no case may the ~~managed care~~defined network plan require notification less than 48 hours after receiving services or before it is medically feasible for the enrollee to provide the notice, whichever is later. ~~A managed care~~An insurer offering a defined network plan may impose no greater penalty than assessing a deductible that may not exceed the lesser of 50% of covered expenses for emergency treatment or $250.00 for failing to comply with emergency treatment notification requirements.

Section 15. Section Ins 9.39 (4) is amended to read:

Ins 9.39 (4) ALTERNATIVE COVERAGE FOR DISENROLLED ENROLLEES. A health maintenance organization or limited service health organization ~~other than a Medicare + Choice plan~~ that has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar alternate insurance coverage to the enrollee. In the case of group certificate holders, the insurance coverage shall be continued until the affected enrollee finds his or her own coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

Section 16. Section Ins 9.40 is amended to read:

Ins 9.40 Required quality assurance plans. (1) In this section:

(a) "HEDIS data" means the elements of the Health Plan Employer Data and Information Set as defined by the National Committee on Quality Assurance.

(b) "Quality assurance" means the measurement and evaluation of the quality and outcomes of medical care provided.

(c) "Preferred provider plan" means a ~~managed care~~defined network plan that meets the definition in s. 609.01 (4), Stats., and Ins 9.01 (15). A preferred provider plan does not include any of the following:

1. Coverage written in whole or in part by a health maintenance organization insurer as defined under s. 600.03(23c), Stats.

2. Coverage where an insurer provides a significant portion of services to its enrollees through direct or indirect risk transference contracts with providers, including but not limited to capitation, withholds, global budgets, or target expected expenses or claims.

3. Coverage which is marketed by an insurer as, or is, a health maintenance organization plan.

(2) By April 1, 2000, an insurer, with respect to a ~~managed care~~defined network plan that is not a preferred provider plan, and by April 1, 2007, with respect to a preferred provider plan, shall submit a quality assurance plan consistent with the requirements of s. 609.32, Stats., to the commissioner. The plans shall submit a quality assurance plan that is consistent with the requirements of s. 609.32, Stats., by April 1 of each subsequent year. The quality assurance plan shall be designed to reasonably assure that health care services provided to enrollees of the ~~managed care~~defined network plan meet the quality of care standards consistent with prevailing standards of medical practice in the community. The quality assurance plan shall document the procedures used to train employees of the ~~managed care~~defined network plan in the content of the quality assurance plan.

(3)~~(a) No later than October 1, 2003, and by October 1 each year prior to 2007, every insurer, with respect to a preferred provider plan, shall submit to the commissioner a quality assurance plan appropriate to the plan structure. The quality assurance plan shall be designed to reasonably assure that health care services provided to enrollees of the preferred provider plan meet the quality of care standards consistent with prevailing standards of medical practice in the community. The quality assurance program shall, to the extent it is reasonably given the nature of the direct and indirect arrangement with the providers and type of plan, be designed to assure the quality of services provided by the plan and participating providers. A preferred provider plan shall include in its quality assurance activities an analysis of the plan's grievances, complaints and appeals, statistically credible administrative claims data and other data that is reasonably attainable. An insurer may:~~

~~1. Include other quality activities such as participant satisfaction surveys, community-based quality improvement collaborations or health initiatives.~~

~~2. Substitute a medical director or contracted medical advisor for the peer review process required under s. 609.32 (1) (f), Stats.~~

~~(b) An insurer, with respect to a preferred provider plan, shall also meet the requirements of s. 609.32 (2) (a), Stats., by October 1, 2002, including all of the following.~~

~~1. Meet the requirements of s. 609.32 (2) (b), Stats., every four years following initial selection of a provider, except that assessment of clinical outcomes is required only to the extent that the plan is reasonably able to measure such.~~

~~2. Direct appointment of a medical director or medical advisor is required only to the extent that the plan assumes direct responsibility for clinical protocols, quality assurance activities and utilization management policies. The insurer may contract for those services otherwise.~~

~~(c) An insurer, with respect to a preferred provider plan, may use the quality assurance plan of a health care provider group or another managed care plan to meet the requirements of par. (a) or (b) and the quality assurance requirements under s. 609.32, Stats., if all of the following apply:~~

~~1. The participating providers in the managed care plan are substantially the same as the participating providers in the health care provider group or managed caredefined network plan for which the quality assurance plan was developed.~~

~~2. The preferred provider plan develops a process to monitor, evaluate and remedy complaints and grievances specific to its health benefit plans and participating providers.~~

~~(a) An insurer, with respect to a preferred provider plan, shall:~~

~~1. By April 1, 2001, establish and file with the commissioner a written plan, including specific goals, activities and time frames to obtain those personnel and other resources, systems, and contractual arrangements by October 1, 2003, reasonably necessary to enable the insurer to carry out the plan described under par. (a) or provide a written plan for compliance with par. (a) or (b) as permitted under par. (c).~~

~~2. Not later than April 1 of each calendar year prior to 2004, submit a progress report on its actions implementing its plan to implement its quality assurance plan or to comply under par. (c).~~

~~(e) This subsection does not apply after March 31, 2007.~~Develop procedures for taking effective and timely remedial action to address issues arising from access to care, continuity of care and quality of care. The remedial action plan shall at least contain all of the following:

(a) Designation of a senior-level staff person responsible for the oversight of the insurer's remedial action plan.

(b) Written plan for the oversight of any functions delegated to other contracted entities.

(c) A procedure for the periodic review of medical management functions performed by the plan or by another contracted entity.

(d) Periodic and regular review of grievances and complaints.

(e) Systematic review of the plan's data regarding the number and type of providers for each provider category including hospital, physician, medical clinic, pharmacy, mental health services and chiropractor including data regarding the ratio of primary care providers to enrollees.

(f) Systematic review of the plan's data on physician profiles, utilization patterns by type of care and medical specialty and hospital utilization data.

(g) Written plan for maintaining the confidentiality of protected information.

(h) Documentation of timely correction of access to care, continuity of care and quality issues identified in the plan. Documentation must include the date of awareness that a issue exists for which a remedial action plan must be initiated; the type of issue that is the focus of the remedial action plan; the person or persons responsible for developing and managing the remedial action plan; the remedial action plan utilized in each situation; the outcome of the plan and established time frame for re-evaluation of the issue to ensure resolution and compliance with the remedial action plan.

(4) All insurers, with respect to ~~managed care~~defined network plans, including preferred provider plans, shall establish and maintain a quality assurance committee and a written policy governing the activities of the quality assurance committee that assigns to the committee responsibility and authority for the quality assurance program. A preferred provider plan shall require all complaints, appeals and grievances relating to quality of care to be reviewed by the quality assurance committee.

(6) Beginning June 1, 2004, every ~~managed care~~defined network plan other than a health maintenance organization plan, shall submit the standardized data set designated by the commissioner and appropriate to the specific plan type for the previous calendar year to the commissioner no later than June 15 of each year.

(7) No later than April 1, 2001, all ~~managed care~~defined network plans, including health maintenance organization plans shall:

(a) Include a summary of its quality assurance plan in its marketing materials.

(b) Include a brief summary of its quality assurance plan and a statement of patient rights and responsibilities with respect to the plan in its certificate of coverage or enrollment materials.

(8) Beginning April 1, 2000, an insurer offering any ~~managed care~~defined network plan shall submit an annual certification for each plan with the commissioner no later than April 1 of each year. The certification shall assert the type of plan and be signed by an officer of the company. OCI shall maintain for public review a current list of health benefit plans, categorized by type.

Section 17. Section Ins 9.42 is amended to read:

Ins 9.42 Compliance program requirements. **(1)** All insurers writing ~~managed care~~defined network plans, preferred provider plans and limited service health organization insurers, except to the extent otherwise exempted under this rule or by statute, are responsible for compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 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, 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.

(2) The insurers shall establish and operate a compliance program that provides reasonable assurance that:

(a) The insurer is in compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07.

(b) Any violations of ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter or any applicable sections including but not limited to s. Ins 9.07 are detected and timely corrections are taken by the insurer.

(3) The insurer's compliance program shall include regular internal audits, including regular audits of any contractors or subcontractors who perform functions relating to compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter or any applicable sections including but not limited to s. Ins 9.07.

(4) An insurer that materially relies upon another party to carry out functions under ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter or any applicable sections including but not limited to s. Ins 9.07, shall:

(a) Contractually require the other party to carry out those functions in compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07.

(e) Include and enforce contractual provisions requiring the other party to give the office access to documentation demonstrating compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07 within 15 days of receipt of notice.

(5) The insurer shall maintain all of the following items in its records:

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

(9) An insurer offering a preferred provider plan that is not also a defined network plan shall comply with this section to the extent applicable.

SECTION 18. This rule shall take effect on the first day of the first month following publication in the Wisconsin administrative register as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this _______ day of ________________, 2002.

____

Connie L. O'Connell
Commissioner of Insurance