**State of Wisconsin** / OFFICE OF THE COMMISSIONER OF INSURANCE

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August 30, 2002

HONORABLE JUDITH ROBSON
SENATE CO-CHAIRPERSON
JOINT COMM FOR REVIEW OF ADM RULES
SOUTH STATE CAPITOL RM 15
MADISON WI 53702

Re: Section Ins Chpt. Ins 9, Wis. Adm. Code, relating to Defined Network Plans

Clearinghouse Rule No. 02-069

Dear Senator Robson:

I am enclosing a copy of this proposed rule which has been submitted to the presiding officers of the legislative houses under s. 227.19 (2), Wis. Stat. A copy of the report required under s. 227.19 (3), Wis. Stat., is also enclosed.

Sincerely,

Connie L. O'Connell

Connie L. O'Connell
Commissioner

CLO:JW
Attachment: 1 copy rule & legislative report

**PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE**

**RENUMBERING, RENUMBERING AND AMENDING, AMENDING**

**AND CREATING A RULE**

To renumber Ins. 9.01(4) to (11); to renumber and amend Ins 9.01 (6) and (12); to amend Chpt. Ins (title), Ins 9.01(intro), (3), (13), (15), (17)(intro), (17)(a) and (c), 9.07 (1), subchpt. III (title), 9.30, 9.31(intro), 9.32(1), (2)(intro), (a) and (d), 9.34(1), 9.34(2) (intro) and (a), 9.35, 9.36, 9.37, 9.38 (intro), 9.38(4)(intro) and (c), 9.39(4), 9.40 (title), (1), (2), (3), (4), (6), (7)(intro) and (8), 9.42 (1), (2), (3), (4)(intro), (a) and (e), (5)(a); and to create Ins 9.34 (1)(b) and (2)(b), 9.42 (9), 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.

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**ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE**

Statutory authority: ss. 601.41 (3), 609.20, 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 of health care services regardless of whether the services are performed by participating or nonparticipating providers. The coverage of services performed by nonparticipating providers is subject to a co-insurance that is not more than an additional 30% greater than the co-insurance applicable for services performed by a participating provider, but not greater than a total co-insurance of 40%. The plan does not include 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.

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

**CHAPTER INS 9**

**~~MANAGED CARE~~DEFINED NETWORK PLANS**

**Section 2.** Ins 9.01 (intro) is amended to read:

Ins 9.01 (intro) In this chapter, and for the purposes of applying ch. 609, Stats.~~addition to the following definitions in s. 609.01, Stats., in this chapter~~:

**Section 3.** 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 insuerer~~about an insurer or its providers with whom the insurer has a direct or indirect contract.

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

**Section 5.** Ins 9.01 (5) is renumbered Ins 9.01(6) and is amended to read:

**(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 6.** Ins 9.01 (12) is renumbered Ins 9.01 (4) and is amended to read:

**(4)** "~~Managed care~~Defined network plan" has the meaning provided under s. 609.01 (~~3e~~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 7.** Ins 9.01 (13), (15), (17)(intro), (a) and (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., including all of the following:

**(a)** The plan does not require, directly or indirectly, a referral to obtain coverage of care by either a participating or nonparticipating provider. For the purpose of this paragraph and s. 609.01 (4), Stats., a utilization management requirement, including a preauthorization requirement, is a referral requirement if the utilization management provision is applied in a discriminatory manner so as to favor preferred providers.

**(b)** The plan provides coverage of health care services regardless of whether the services are performed by participating or nonparticipating providers. For the purpose of this paragraph and s. 609.01(4), Stats., a plan provides coverage regardless of whether the services are performed by participating or nonparticipating providers only if:

1. The coverage of services performed by nonparticipating providers is subject to a co-insurance that is not more than an additional 30% greater than the co-insurance applicable for services performed by a participating provider, but not greater than a total co-insurance of 40%; or,

2. The coverage of services performed by nonparticipating providers is subject to costsharing provisions that comply with all of the following:

a. The costsharing provisions are filed with the commissioner under s. 631.20, Stats., and are not disapproved by the commissioner.

b. The costsharing provisions provide substantial coverage for services performed by nonparticipating providers compared to the coverage for services performed by participating providers.

c. The insurer demonstrates by clear and convincing evidence that the costsharing provisions retain coverage for services performed by nonparticipating providers that is at least equivalent to the coverage provided under subd. 1.

d. The insurer submits, with any filing under this subdivision, an actuarial study demonstrating, and certification from a qualified actuary stating, that the costsharing provisions comply with subds. 2 b. and c.

**(c)** Except as permitted under par. (b) 2, the plan does not include any deductibles, copays or other costsharing provisions that do not apply equally to services performed by both participating and nonparticipating providers.

**(d)** The plan does not include any material exclusions, maximum limits or conditions to coverage that do not apply equally to services performed by participating and nonparticipating providers.

**(e)** The plan does not include any financial incentives for use of providers other than those permitted under par. (b).

**(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 8.** Ins 9.07(1) 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~~ or 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~~contains 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 9.** Subchapter III (title) Ins 9 is amended to read:

**SUBCHAPTER III: MARKET CONDUCT STANDARDS FOR ~~MANAGED CARE~~DEFINED NETWORK PLANS.**

**Section 10.** Ins 9.30 and 9.31 (intro) 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~~offering ~~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 11.** Ins 9.32 (1), (2)(intro), (a) and (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~~offering ~~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 12.** Ins 9.34 (1) is amended to read:

**Ins 9.34 Access standards (1)** ANNUAL CERTIFICATION. **(a)** 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.

**Section 13.** Ins 9.34 (1) (b) is created to read:

**Ins 9.34 (1)(b)** An insurer offering a preferred provider plan shall file an annual certification to the commissioner, on a form prescribed by the commissioner and signed by an officer of the company, certifying compliance with ss. 609.22 (1), (4m), (5), (6) and (8), Stats., and s. Ins 9.32 for the preceding year. The certification is to be filed within 3 months after the effective date of this section . . . .[revisor to insert date], and thereafter, no later than August 1 of each year.

Note: A copy of the certification of access standards form required under par. (1)(a), OCI26-110, and par. (1)(b), OCI26-111, may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI, 53707-7873.

**Section 14.** Ins 9.34 (2)(intro) and (2) are amended to read:

**Ins 9.34 (2)** ADDITIONAL REQUIREMENTS. **(a)** An insurer offering a ~~managed care~~defined network plan that is not a preferred provider plan shall have the capability to do all of the following:

~~(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~~. Insurers shall also provide benefits that are representative the usual practice in the local area with respect to ~~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.

**Section 15.** Ins 9.34 (2)(b) is created to read:

**Ins 9.34 (2)(b)** An insurer offering a preferred provider plan shall do all of the following:

1. Provide covered benefits by plan providers with reasonable promptness. Insurers shall also provide benefits that are representative of the normal practice and standards in the local area, as appropriate to the type of plan, with respect to hours of operation, waiting times, and availability of after hours care. Geographic availability shall reflect the usual medical travel times within the community.

2. Provide an adequate number of participating providers in each geographic area to service all insureds in that area. The insurer shall provide an adequate number of participating primary providers in each geographic area to ensure that at all times there is at least one provider who is accessible, qualified and accepting new enrollees with respect to covered benefits. This does not require preferred providers plans to offer a choice of participating providers in each geographic areas.

3. Provide 24-hour 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 16.** 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 all of 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)** An insurer offering a preferred provider plan may either comply with sub. (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 shall enforce the contract and ensure 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 17.** Ins 9.38 (intro) and 9.38(4)(intro) and (c) 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 18.** 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 19.** Ins 9.40(title), (1)(c), (2), (3), (4), (6), (7)(intro) and (8) are amended to read:

**Ins 9.40 Required quality assurance and remedial action plans. (1)** In this section:

~~(c) "Preferred provider plan" means a managed caredefined 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.~~