(2) (a) 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.

(b) Defined network plans that are not also preferred provider plans or health maintenance organization plans shall submit a quality assurance plan consistent with the requirements of par. (a) and s. 609.32, Stats., to the commissioner by April 1, 2006, and April 1 of each subsequent year.

(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 care~~defined 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.~~Insurers offering preferred provider plans shall develop procedures for taking effective and timely remedial action to address issues arising from access to and continuity of care for participating providers. 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) A 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, complaints and OCI complaints.

(e) A written plan for maintaining the confidentiality of protected information.

(f) Documentation of timely correction of access to and continuity of care issues identified in the plan. Documentation must include; the date of awareness that an 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 by 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~~ All complaints, OCI complaints, appeals and grievances relating to quality of care ~~to~~ shall be reviewed by the quality assurance committee.

(6) Beginning June 1, ~~2004~~2005, 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 plans, including health maintenance organization plans shall:~~ with respect to defined network plans that are health maintenance organization plans, and by April 1, 2006, for defined network plans that are not also preferred provider plans or health maintenance organization plans, shall do all of the following:

(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 20. Ins 9.42 (1), (2), (3), (4)(intro), (a) and (e), (5)(a) are amended to read:

Ins 9.42 Compliance program requirements. (1) All insurers ~~writing~~offering ~~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) (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.

Section 21. Ins 9.42(9) is created to read:

(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 22. 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 30 day of August, 2002.

Connie L. O'Connell
Commissioner of Insurance

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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

Wisconsin.gov

August 30, 2002

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REPORT ON Section Ins Chpt. INS 9, Wis. Adm. Code, relating to
Defined Network Plans

Clearinghouse Rule No 02-069
Submitted Under s. 227.19 (3), Stats.
The proposed rule-making order is attached.

(a) Statement of need for the proposed rule

The proposed rule implements and interprets the changes made to Chpt. 609, Wis. Stats, by 2001 Wisconsin Act 16, wherein references to managed care plans were modified to defined network plans. Most of the revisions are based on the change in terminology but 2001 Wis. Act 16 also modified the definition and applicability of various requirements for insurers offering preferred provider plans.

(b) Modifications made in proposed rule based on testimony at public hearing:

Several sections were modified based upon testimony received at the public hearing including clarification of the definition of preferred provider plan, quality assurance requirements for preferred provider plans and removal of reference to 609.22 (4), Stats., as it does not apply to preferred provider plans.

(c) Persons who appeared or registered regarding the proposed rule:

Appearances For:
Joe Kachelski, Wisconsin Association of Health Plans
Louise Trubek, Center for Public Representation

Appearances Against:
Carol Rubin, WEA Insurance Company
Robert Wood, WPS Insurance Company
Dan Schwartzer, Wisconsin Association of Provider Networks
J.P. Wieske, AMS Insurance Company
Pat Osborne, Wisconsin Association of Life and Health Insurers
Ron Hermes, Health Insurance Association of America

Appearances For Information:
Joe Kachelski, Wisconsin Association of Health Plan

Registrations For:
None

Registrations Against:
None

Registrations Neither for nor against:
Mary Haffenbredl, Atrium Health Plan

Letters received:
Center for Public Representation
Wisconsin Association of Provider Networks
American Medical Security
Wisconsin Association of Life & Health Insurers
Health Insurance Association of America
Wisconsin Association of Health Plans
WEA Trust
American Medical Security
WPS Insurance Company

(d) Response to Legislative Council staff recommendations

All comments were addressed. The rule has been revised to make it clear that the agency is interpreting the statutory definition of Preferred Provider Plan as contemplated by SS. 227.11(2), Wis. Stats. Section 227.11(2), Wis. Stats., states that each agency that administers a statute "may promulgate rules interpreting any statute enforced or administered by it if the agency considers it necessary to effectuate the purpose of the statute. . . ." The Office clearly has the authority and necessity to adopt the provision now contained in s. INS 9.01(15) of the proposed rule. That provision has been revised, as suggested by the Legislative Council, to make it clear the Office is interpreting the definition of Preferred Provider Plan under s. 609.01(4), Wis. Stats., rather than adopting an unrelated substantive provision.

Section 609.01(4), Wis. Stats., defines a Preferred Provider Plan as "making available to . . . enrollees, without referral . . . coverage . . . regardless of whether the health care services are performed by participating or nonparticipating providers." When 2001 Wisconsin Act 16 was pending in the legislature the Commissioner sent a letter to the principle sponsor and Chair of the Assembly Insurance Committee, the Honorable Phil Montgomery, detailing the Commissioner's understanding of this provision. (See attached letter dated July 11, 2001 to the Honorable Phil Montgomery from Connie L. O'Connell, Commissioner of Insurance.) The letter discusses, among other matters, the provision that required coverage be provided "regardless" of whether the provider performing services is a participating or nonparticipating provider. The letter states that this can only mean that the coverage for services performed by nonparticipating providers is "substantial."

The proposed rule correctly interprets the Preferred Provider Plan definition by stating that coverage is provided "regardless" only if the coverage is not reduced by more than 30% and if there remains significant coverage (at least 60%) for services performed by nonparticipating providers.

(e) Regulatory flexibility analysis

No issues were raised by small businesses during the hearing on the proposed rule. The proposed rule does not impose any additional reporting requirements on small businesses. The proposed rule does not require any additional measures or investments by small businesses.

(f) Fiscal Effect

See fiscal estimate attached to proposed rule.

Enclosures: Legislative Council Staff Recommendations
Letter of July 11, 2001, to the Honorable Phil Montgomery

LCRC FORM 3

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Ronald Sklansky
Clearinghouse Director

Richard Sweet
Clearinghouse Assistant Director

Terry C. Anderson
Legislative Council Director

Laura D. Rose
Legislative Council Deputy Director

PROCESSING INSTRUCTIONS TO AGENCY HEADS

[ENCLOSED ARE THE SENATE AND ASSEMBLY RULE JACKETS CONTAINING THE LEGISLATIVE COUNCIL CLEARINGHOUSE REPORT. AN ADDITIONAL COPY OF THE CLEARINGHOUSE REPORT IS ENCLOSED FOR YOUR FILES.]

PLEASE NOTE: Your agency must complete the following steps in the legislative process of administrative rule review:

1. On the appropriate line on the face of both clearinghouse rule jackets, enter, in column 1, the appropriate date and, in column 2, "Report Received by Agency."

2. On the appropriate line or lines on the face of both clearinghouse rule jackets, enter, in column 1, the appropriate date or dates and, in column 2, "Public Hearing Held" OR "Public Hearing Not Required."

3. Enclose in both clearinghouse rule jackets, in triplicate, the notice and report required by s. 227.19 (2) and (3), Stats. [The report includes the rule in final draft form.]

4. Notify the presiding officer of the Senate and Assembly that the rule is in final draft form by hand delivering the Senate clearinghouse rule jacket to the Senate Chief Clerk and the Assembly clearinghouse rule jacket to the Assembly Chief Clerk. At the time of this submission, on the appropriate line on the face of the clearinghouse rule jacket, each Chief Clerk will enter, in column 1, the appropriate date and, in column 2, "Report Received from Agency." Each clearinghouse rule jacket will be promptly delivered to each presiding officer for referral of the notice and report to a standing committee in each house.

5. If the agency does not proceed with the rule–making process on this rule, on the appropriate line on the face of both clearinghouse rule jackets, enter, in column 1, the appropriate date and, in column 2, "Rule Draft Withdrawn by Agency" and hand deliver the Senate clearinghouse rule jacket to the Senate Chief Clerk and the Assembly clearinghouse rule jacket to the Assembly Chief Clerk.

FOR YOUR INFORMATION: A record of all actions taken on administrative rules is contained in the Bulletin of Proceedings of the Wisconsin Legislature. The clearinghouse rule jackets will be retained by the Legislature as a permanent record.

[See reverse side for jacket sample.]

WLCS
TCA:jal;kja
03/01

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LCRC
FORM 2

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Ronald Sklansky
Clearinghouse Director

Richard Sweet
Clearinghouse Assistant Director

Terry C. Anderson
Legislative Council Director

Laura D. Rose
Legislative Council Deputy Director

CLEARINGHOUSE REPORT TO AGENCY

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

CLEARINGHOUSE RULE **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 ☑

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

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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

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July 11, 2001

Honorable Phil Montgomery
State Representative
State Capitol – 129 W
Madison WI 53707

Dear Representative Montgomery:

You have asked for OCI's interpretation of the budget amendment regarding defined network plans. This language has the following impacts:

Definition of managed care plan – The amendment replaces the term "managed care plan" with the term "defined network plan" in the statutes.

Definition of preferred provider plan – The amendment seems to attempt to not treat all preferred provider plans (PPP's) alike, loosening regulations on PPP's that do not require, or impose financial incentives related to, referrals for access to a participating or non-participating provider. I believe the amendment attempts to prevent PPP's that require a referral from taking advantage of the more relaxed standards. However, you should note that these provisions also appear to have the inadvertent result of exempting vision and dental plans that require referrals from some of the long standing provisions that apply to them, including s. 609.17 and 609.20, Wis. Stats. It does appear clear that any referral requirement or incentive, even if under the pretext of a utilization management process, such as pre-authorization requirements, would disqualify a plan from the proposal's definition of preferred provider plan.

Another provision which purports to ensure off-panel coverage is available from PPP's is troublesome. Under the language if a PPP does not "cover" the same services when performed by a provider outside the network that it covers by an in-network provider, it is held to the stricter regulations. However, the term "cover" is not defined. We assume that the intent is that the "coverage" for out of network providers must be substantial and that material exclusions, deductibles, maximum limits or other conditions uniquely applied to out of network provider services resulting in significantly limited out of network benefits would not be considered "coverage.".

Patient Protections – the amendment modifies or eliminates the applicability of certain patient protections to certain preferred provider plans.

Access standards – As under current law, all DBP's are required to have participating plan providers who are accepting patients within a reasonable distance of the enrollee.

The proposed legislation retains the requirement under current law that DBP's, other than PPP's, have a choice of participating providers in all geographic areas. The expectations for geographic location of participating providers vary based on the usual medical travel times in the community. However, under the proposed legislation, a PPP will not be required to provide a choice of participating providers in all geographic areas. A PPP will still be required to provide an adequate number of participating providers in each geographic area to service all insureds in that area. .

Telephone access - PPP's would not have to provide enrollees with 24 hour to ensure that enrollees have adequate access to routine health services. Under this provision, a PPP would still have to provide telephone access for emergency care 24 hours per day.

Notice of continuity of care – Whenever a participating provider's participation with the plan terminates, the PPP must notify enrollees. The PPP may either notify the enrollee directly or may arrange for the provider to notify the enrollee. The PPP remains responsible for ensuring that notification is sent but may contract for the service.

Quality Assurance Plans – PPP's would not be required to develop quality assurance standards related to access to, and continuity and quality of care. However, they would still be responsible for developing procedures for remedial action to address quality problems in each of these areas.

Medical Director – PPP's or its designee that assumes direct responsibility for clinical protocols and utilization management of the plan would be required to appoint a physician as medical director. Other PPP's would not be required to appoint a medical director.

I believe I have identified the major changes proposed by the proposed legislation.

Sincerely,

Connie L. O'Connell

Connie L. O'Connell
Commissioner