WISCONSIN STATE LEGISLATURE
COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

File Naming Example:

Record of Comm. Proceedings … RCP

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

COMMITTEE NOTICES …

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

- *Committee Reports … CR*
- **

- *Executive Sessions … ES*
- **

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

- -

INFORMATION COLLECTED BY COMMITTEE CLERK FOR AND AGAINST PROPOSAL

- *Appointments … Appt*
- **

Name:

- *Clearinghouse Rules … CRule*
- **05hr_CRule_05-059_AC-In_pt01**

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

- *Miscellaneous … Misc*
- **

Vote Record

Committee on Insurance

Date: October 13, 2005

Bill Number: _____

Moved by: Rep. Gielow Seconded by: Rep. Montgomery

Motion: Request for Modification/Contingent Objection Clearinghouse Rule 05-59

"MOVED, that the Assembly Committee on Insurance, pursuant to s. 227.19 (4) (b) 2., Stats., requests the Commissioner of Insurance to consider making modifications to Clearinghouse Rule 05-59, relating to revising requirements for insurers offering defined network plans, preferred provider plans, and limited service health organizations in order to comply with recent changes in state laws.

FURTHER MOVED, that if the Commissioner fails to notify the Chair of the Assembly Committee on Insurance in writing by 5:00 p.m. on November 7, 2005, that the Commissioner will agree to consider making modifications to Clearinghouse Rule 05-59, the Assembly Committee objects to the promulgation of Clearinghouse Rule 05-59 under s. 227.19 (4) (d) 3., 4., and 6., Stats., on the concerns that the rule may overreach legislative intent, may have portions in conflict with state law, and may impose undue hardship on patients and providers."

Committee Member	Aye	No	Absent	Not Voting
Representative Ann Nischke, Chair	☒	☐	☐	☐
Representative Steve Wieckert	☒	☐	☐	☐
Representative Gregg Underheim	☐	☐	☒	☐
Representative Phil Montgomery	☒	☐	☐	☐
Representative Terri McCormick	☒	☐	☐	☐
Representative Curtis Gielow	☒	☐	☐	☐
Representative Karl Van Roy	☒	☐	☐	☐
Representative Joan Ballweg	☒	☐	☐	☐
Representative Terry Moulton	☒	☐	☐	☐
Representative David Cullen	☐	☐	☒	☐
Representative John Lehman	☐	☐	☒	☐
Representative Tony Staskunas	☐	☐	☒	☐
Representative Terese Berceau	☒	☐	☐	☐
Representative Thomas Nelson	☐	☒	☐	☐
Representative Michael Sheridan	☐	☒	☐	☐
Totals:	9	2	4	0

☒ Motion Carried ☐ Motion Failed

Motion—Request for Modification/Contingent Objection
Clearinghouse Rule 05-59

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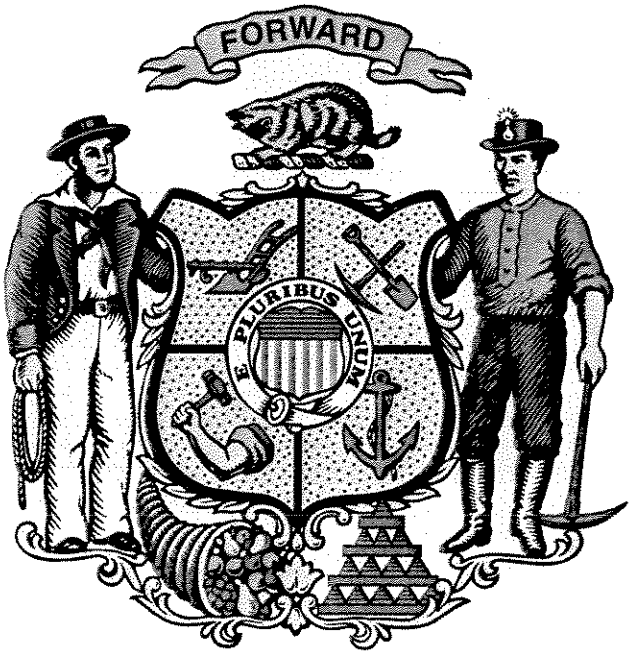
on patients + providers

concerns that the rule may overreach legislative intent, may be in conflict with state law, have portions


FORWARD
E PLURIBUS UNUM

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Connie L. O'Connell
Commissioner

Legal Unit
121 East Wilson Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 267-9586 • Fax: (608) 264-6228
E-Mail: Legal@oci.state.wi.us
http://badger.state.wi.us/agencies/oci_home.htm

December 16, 1999

Mr. Daniel J. Schwartzer
Wisconsin Association
Of Health Underwriters
6441 Enterprise La.
Suite 102-A
Madison, WI 53719-1139

Re: Access to Providers

Dear Mr. Schwartzer:

Commissioner O'Connell asked that I respond to your letter of December 1, 1999, in which you ask for the Office's advice with respect to the application of s. 609.22, Wis. Stats., and s. INS 9.34, Wis. Adm. Code, as proposed in Clearing House Rule #98-183. You ask how an insurer would "demonstrate" compliance with those provisions.

Section 609.22, Wis. Stats., requires a managed care plan to include in its provider network a sufficient number of providers to meet the anticipated needs of enrollees. In addition it requires a managed care plan to ensure that each enrollee has adequate choice among participating providers and that participating providers are accessible and qualified. The proposed rule interprets s. 609.22, Wis. Stats., as permitting insurers to comply with its provider access requirements by establishing a provider network which its accessible with "reasonable" promptness. "Reasonable" will be evaluated by the Office in the context of all the circumstances, including the nature of the provider, the nature of the provider's services, and the insureds' need for the services. In addition, as stated in the proposed rule, hours of operation, waiting times, and availability of after hours care may reflect "usual practices" in the local area and availability may reflect the "usual" travel times in the community.

The Office anticipates an insurer will demonstrate compliance with this requirement by maintaining records showing its direct or indirect contractual arrangements with an adequate network of providers, that its contracts include provisions addressing the access issues discussed above, and that it is monitoring and enforcing the contractual provisions. The Office expects that the primary means of monitoring compliance with contractual provisions governing hours of operation, waiting times, and availability of after hours care will be prompt handling and monitoring of complaints, grievance and appeals and appropriate corrective action when deficiencies are identified.

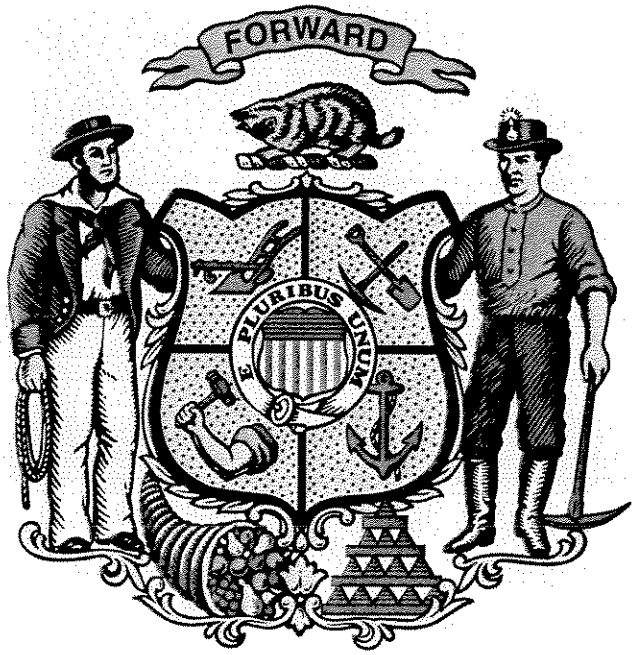
In summary, the statute, s. 609.22, Wis. Stats., as interpreted by the proposed rule, anticipates that insurers will take reasonable measures to provide, and monitor access to, "in-network" providers. Thank you for the opportunity to clarify this issue.

Sincerely,

Fred Nepple
General Counsel

cc Commissioner Connie L. O'Connell

FN: fn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Daniel J. Schwartzer
Executive Director

(608) 243-1007
Fax (608) 241-7790

2810 Crossroads Dr., Ste. 3000 • Madison, WI 53718

WAPN
WISCONSIN ASSOCIATION
OF PROVIDER NETWORKS

April 18, 2000

Commissioner Connie O'Connell
Office of the Commissioner of Insurance
State of Wisconsin
121 E. Wilson St.
Madison, WI 53703

Dear Commissioner O'Connell:

In some of our past conversations, I had indicated the possibility of several Preferred Provider Plans forming an association. I would like to inform you that four Wisconsin based provider network organizations have formed an association called the Wisconsin Association of Provider Networks (WAPN). I have been contracted to represent this organization as the Executive Director. Combined, our members represent nearly 1.4 million Wisconsin consumers, of which roughly 550,000 of those consumers are insured through fully insured plans and, thus covered under state insurance laws. In 1999, our members contracted for nearly $1.8 billion dollars in health care costs.

Our primary goal as an association is to ensure the continued viability of the products of our members so that consumers continue to have choices within the health insurance marketplace. As you know, Chapter 609 of the Wisconsin Statutes, and Ins 9 of the Wisconsin Administrative Code have raised some concerns on behalf of our members. Our concerns are regarding the Quality Assurance and Access Standards provisions. It is our opinion that these provisions include language which makes compliance extremely difficult relative to preferred provider plans. Based on the number of Wisconsin residents represented by WAPN members, this affects a significant portion of the marketplace.

WAPN is looking for both administrative and statutory solutions relative to our concerns. The purpose of my letter today is to continue to explore administrative solutions for Ins. 9.34. In our previous discussions, I had indicated that the contractual language found in most provider network agreements do not provide for control over the providers' operations. However, there is a provision in most of these agreements that require the provider to treat the plan's patient in the same manner as the provider would treat all of their patients. A sample of this type of language is as follows:

"The provider agrees to provide covered services to covered persons/subscribers/beneficiaries in accordance with the normal practices and procedures of the affected practice or hospital, and with the same standards and availability as offered to other patients."

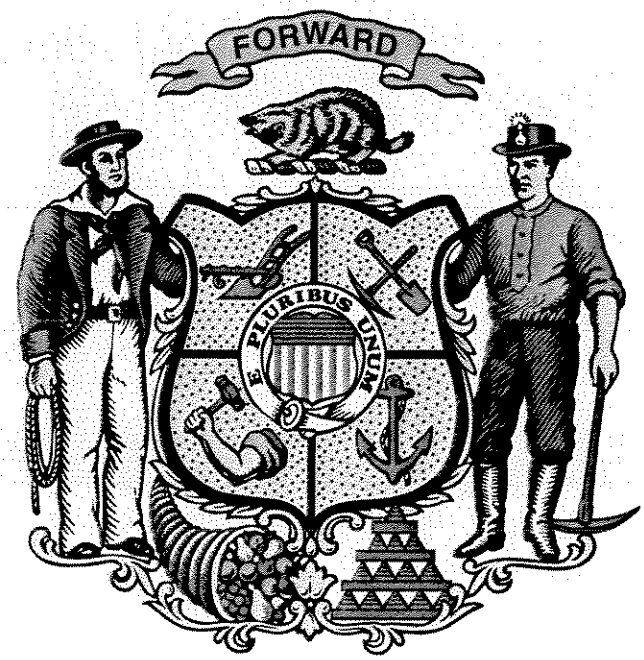
I would like to ask your opinion if the above provision, or language similar to the above provision, would satisfy the requirements of Ins 9.34. Please respond at your earliest convenience, and if you have any questions regarding my request, please do not hesitate to contact me.

Thank you for your consideration.

Sincerely,

Daniel J. Schwartzer
Executive Director

DJS/jlr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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor
Connie L. O'Connell
Commissioner

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June 8, 2000

MR. DANIEL J SCHWARTZER
EXECUTIVE DIRECTOR
WISCONSIN ASSOCIATION OF PROVIDER NETWORKS
2810 CROSSROADS DRIVE, STE 3000
MADISON WI 53718

Re: Ins 9.34 Access Standards

Dear Mr. Schwartzer:

Thank you for your inquiry dated April 18, 2000. Your letter requests an opinion as to whether the sample contract provision noted in your letter would satisfy the requirements of s. Ins 9.34, Wis. Adm. Code.

The sample provision noted in your letter requires providers under contract to a network to treat all patients, regardless of insurance, similarly. However, s. Ins 9.34 requires all of the following:

> Ins 9.34 (2) Additional Requirements. An insurer offering a managed care plan shall have the capability to:
> (a) Provide covered benefits by plan providers with reasonable promptness with respect to geographic location, hours of operation, waiting times for appointments in providers offices and after hours care. The hours of operation, waiting times, and availability of after hours care shall reflect the usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community.
> (b) Have sufficient number and type of plan providers to adequately deliver all covered services based on demographics and health status of current and expected enrollees served by the plan.
> (c) Provide 24-hour nationwide toll-free telephone access for its enrollees to the plan or to a participating provider for authorization for care which is covered by the plan.

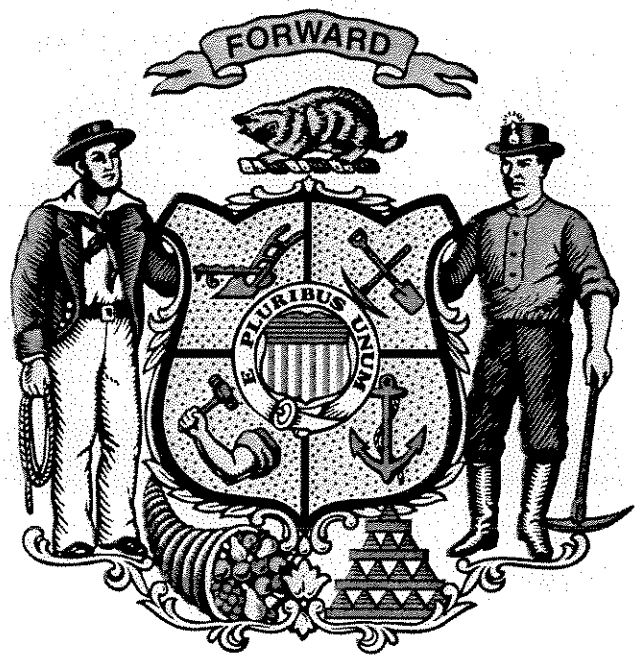
The language submitted in your letter establishes that the contract with providers is to offer services to covered persons in accordance with "normal practices and procedures of the affected practice or hospital". However, the language you submitted does not require providers to adhere to usual practices in the local area with respect to waiting and travel times. Additionally, consistent with Ins 9.42, we would expect that an insurer would also have a procedure or mechanism to monitor provider compliance with the rule requirements.

I hope this responds to your concerns. Please contact me should you have further questions.

Sincerely,

Eileen Mallow
Assistant Deputy Commissioner

cc: Fred Nepple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October 10, 2005

Golden Rule Insurance Company

Concerns with Wisconsin Clearinghouse Rule 05-059

(Wisconsin Insurance Regulation Chapter 9)

- Some of the proposed changes to Wisconsin Insurance Regulation Chapter 9 (INS 9) create regulatory policy that exceeds statutory language.

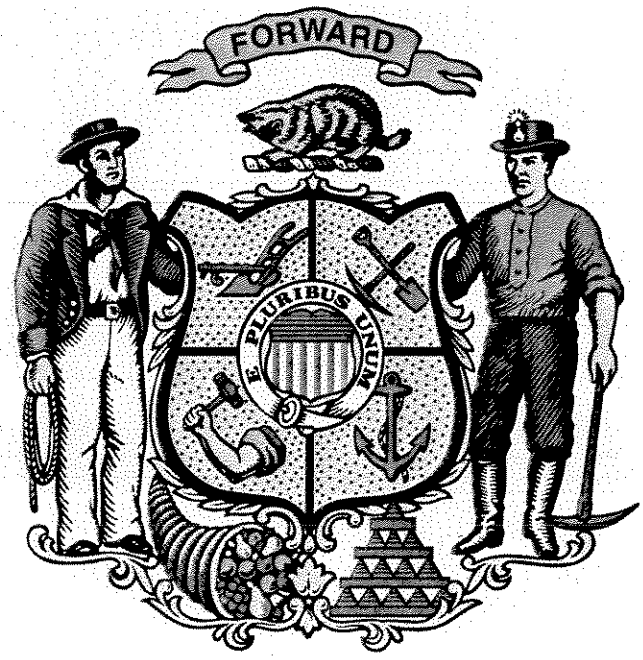
- These changes create regulations that were never intended by the legislature in 2001 Wisconsin Act 16.

- Some specific regulations contained in the rule will restrict the types of health insurance policies available to consumers in Wisconsin.

- It requires a retroactive compliance on all current policy forms previously filed and approved by OCI.

- Wisconsin policy owners will be affected as insurance carriers try to bring all policies into compliance with this regulatory framework.

Josh Watson
Government Relations
Golden Rule Insurance Company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ANN
Nischke
www.RepNischke.com

TO: MEMBERS
ASSEMBLY COMMITTEE ON INSURANCE

From: Representative Ann Nischke, Chair
Committee on Insurance

Date: October 12, 2005

RE: Legislative Council Memo on CHR 05-59

Please find attached a memo on CHR 05-59 attached (a hardcopy should have been already delivered to your office). Additional documents, including testimony, will be posted on the committee section of my website (www.repnischke.com) as it becomes available.

If you have any questions or concerns, please feel free to contact Adam Peer in my office.

AMN:asp

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

WISCONSIN LEGISLATIVE COUNCIL

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

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

FROM: Joyce L. Kiel, Senior Staff Attorney

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

DATE: October 12, 2005

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

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

PROCEDURAL BACKGROUND

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

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http://www.legis.state.wi.us/lc

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

GENERAL BACKGROUND

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

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

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

Definitions of Types of Plans

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Consideration provided to participating providers is capitated.

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

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

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

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

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

Statutory Requirements

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

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

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

Rule-Making Authority

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

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

PROVISIONS OF CR 05-59

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

COMMENTS ABOUT CR 05-59

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

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

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

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

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

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

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

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

4. Section 609.35, Stats., provides that a PPP that does not "cover the same services" when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to certain requirements that are otherwise imposed only on defined network plans that are not PPPs. Section Ins 9.25 (1) provides that, for the purposes of s. 609.35, Stats., a PPP is considered to be covering the same services when performed by a nonparticipating provider as when performed by a participating provider (and, thus, may avoid being subjected to the requirements specified in ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), Stats., only if the insured complies with all six subsections in s. Ins 9.25. The following comments apply to these provisions:

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

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

c. Section Ins 9.25 (2) permits an insurer to exceed the coinsurance, deductible, and co-payment differentials to the extent "reasonably necessary" to encourage use of participating providers or centers of excellence for transplant or other unique disease treatment under certain circumstances, preventive health care services limited to immunizations, and certain other services when the benefit would exceed specific mandated benefits under certain circumstances. The rule does not explain how, on what basis, and by whom it is determined whether, and to what extent, exceeding the differentials is "reasonably necessary."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Various grammar issues include:

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

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

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

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

COMMITTEE OPTIONS

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

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

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

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

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

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

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

JLK:ksm

Attachments

Attachment 1

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

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

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

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

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

LSHO

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

Key

- Defined Network Plan
- Preferred Provider Plan (PPP)
- Limited Service Health Organization (LSHO)
- Limited Scope Plan (as defined in proposed s. Ins 9.01 (10m) in Clearinghouse Rule 05-59)

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

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

ATTACHMENT 2

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

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

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

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

[3] "Cover the same services" refers to the provision in s. 609.35, Stats., that a PPP that does not "cover the same services" when performed by a nonparticipating provider that it covers when those services are performed by a participating provider is subject to certain requirements that are otherwise imposed only on a defined network plan that is not a PPP.

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

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

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

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

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

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

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

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October 12, 2005

Attachment 3

Listing of Certain Provisions in Clearinghouse Rule 05-59

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

CR 05-59 includes provisions that do the following:

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

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

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

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

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

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

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

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

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

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

2. ***ADDITIONAL REQUIREMENTS FOR INSURERS OFFERING A PPP***

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

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

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

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

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

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

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

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

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

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

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

4. *ACCESS STANDARDS FOR PPPS*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. *DATA SUBMISSION*

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

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

7. *MISCELLANEOUS*

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

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

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

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

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

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

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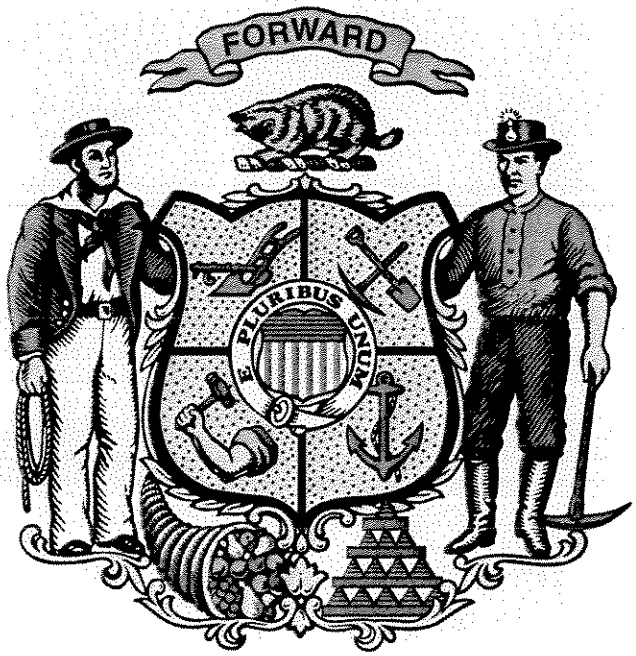
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Summary of Testimony for Clearinghouse Rule 05-059
October 13, 2005

Thank you for the opportunity to provide testimony on Clearinghouse Rule 05-059. This is my first opportunity to provide testimony in a setting like this, and I consider it a privilege to appear before you today.

My name is Paul Sabin. I am the Vice President of Network Development for HealthEOS by Multiplan, a Preferred Provider Organization (PPO) based in Brookfield, Wisconsin. In this role, I am responsible for provider contracting and for maintaining provider networks so that patients can access health care services from the many qualified health care professionals, hospitals, and ancillary facilities throughout the state. Prior to my current role, I worked as the Vice President-Managed Care for Covenant Healthcare System in Milwaukee, Wisconsin. My employment at this major health care provider system, along with my current role has allowed me to gain valuable insight and experience on some of the issues before us today. It has further provided me with the opportunity to examine the issues from both sides of the negotiating table – from the provider side and the network side.

I certainly have a number of concerns with the proposed regulations. In addition to the areas I will address in some detail in a moment, I have concern with mandating specific coverage levels at a time when there is a lot of experimentation in the marketplace. This experimentation is taking place in an effort to find an effective mix of adequate coverage for patients while requiring them to become more actively involved in the decisions they make. It seems to me that we should allow this experimentation process to take place, free from excessive intervention, for a reasonable period of time to see whether there is a positive impact.

Not surprisingly, most of my detailed comments today pertain to two (2) areas. These areas include the so-called "Access Standards" as well as the "Ancillary Providers" issue. By the term Ancillary Providers, I am referring to anesthesiologists, emergency department physicians, radiologists, and pathologists. I emphasize these specific areas because the proposed regulation imposes requirements on PPOs through the provider contracting process.

In general, the provider contracting process is a difficult, time-consuming endeavor. It is not uncommon for discussions with large, sophisticated provider systems, clinics, and hospitals to take a full year to complete. Adding provisions to an already complex and lengthy negotiation process will only make it more difficult and contentious, especially considering the subjects that are being proposed.

Access Standards
With respect to Access Standards (Ins9.32 (2)(a) and Ins 9.32 (2)(b)), the proposed regulation appears to ask us, through the use of the provider contracting process, to regulate behavior on behalf of the provider community. As we work with physician

offices, hospitals and so forth throughout the state, we are dealing with literally thousands of independent organizations, each with their own particular way of conducting business. These organizations, for the most part should be free to serve the market as they see fit. Asking us to regulate business practices in areas such as hours of operation, waiting times, and after hours care will place us in a constant state of conflict with the provider community over these topics. Just negotiating these topics would be very difficult, but forcing providers by contract terms to comply with a rigid standard would make this process impossible.

Even if we were able to achieve the desired effect of this regulation, we would not be in a good position to monitor and comply with the provisions. Our clients, the ultimate payors of health care services would be penalized for actions or inactions of independent organizations making decisions in the marketplace in accord with their own interests. This is simply too much risk to have for a payor, and it is not possible to achieve as a PPO.

If regulation of hours of operation, waiting times, and after hours care throughout the state is a good idea – and I am not convinced at this point that it is – it would be better to do so by law or by regulation directly with those entities rather than to require that of us, as a PPO working on a provider contract with these providers.

This proposal is too far-reaching, it is too difficult to monitor, and there is too much risk for the ultimate payors of health care services for which they have limited or no control.

Ancillary Providers

As for Ancillary Providers (Ins 9.32 (2)(c), Ins 9.32 (2)(e), and Ins 9.32 (2)(f)), I acknowledge that this is a difficult issue for patients. We are discussing, of course, patients receiving care at an appropriate in-plan facility to receive care and maximize insurance coverage only to find out that certain specialists involved in the case (anesthesiologists, radiologists, pathologists and emergency department physicians) are not in the plan. This forces higher out-of-pocket expense for patients. Please note that most of these physicians work with things and not patients. They administer anesthesia, they read images, and they test and analyze blood and specimens. At times, services are performed by physicians who have never had a one-on-one interaction with the patient. I have witnessed this issue from all sides, as a PPO representative dealing with members, as a provider dealing with angry patients, and as a patient.

The proposed regulation is not workable in my view. It requires again that we use provider contracts to regulate behavior, and again it penalizes the ultimate payor of health care services for any mishaps.

This regulation is directed at the wrong place. Given the structure of exclusive agreements that ancillary providers have with hospitals and other facilities, other parties ought to be responsible for addressing this issue.

Ancillary providers, with whom provider contracting is already very difficult, will become even more problematic if these providers know that by not reaching agreement with PPOs, they will still be treated as in-plan providers. We are, through this regulation, creating a condition for them *not* to reach agreement with us. This will have the effect of increasing costs in this state at a time when health care costs in general and physician costs in particular are high relative to other states.

Again, I certainly acknowledge the frustrating nature of this issue. I just question the methods proposed to address it. Other alternatives should be explored and carefully analyzed. This proposal does not represent the ultimate solution.

I would be pleased to discuss these matters in greater detail and to address any questions you may have. Thank you for the opportunity to share my thoughts with you.

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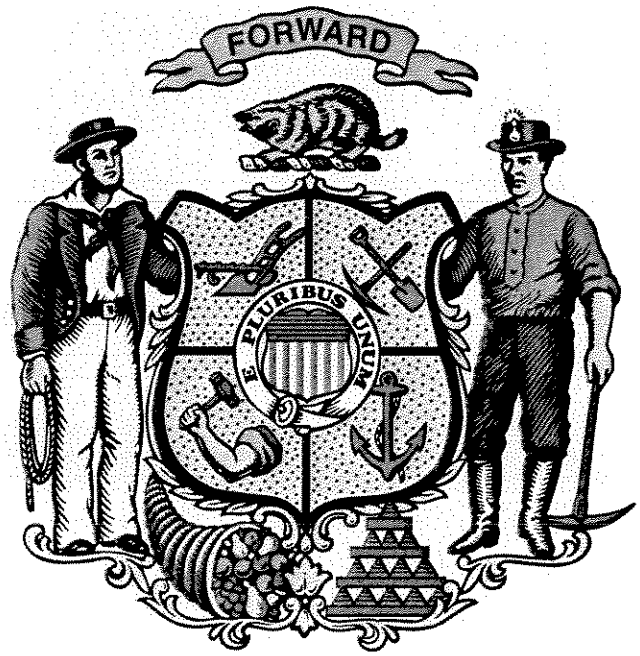
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The Voice of Small Business®

WISCONSIN

Statement Before the
Senate Committee on Agriculture and Insurance
And
Assembly Committee on Insurance

By

Bill G. Smith
State Director
National Federation of Independent Business
Wisconsin Chapter

Thursday, October 13, 2005
Clearinghouse Rule 05-059

Senator Kapanke, Representative Nischke and members of the committee, I appreciate the opportunity to participate in today's hearing for Clearinghouse Rule 05-059.

As you know, the cost and availability of health insurance has been a top issue of concern by our state's small business owners for many years. Since 1986, according to NFIB's Problems and Priorities Studies, the cost of health insurance has been ranked by small business owners as their number one concern.

Obviously, whenever there is a proposal that may impact the cost of health insurance we give that issue our closest attention.

Two years ago, we were very pleased the Legislature approved and the Governor signed into law the Small Business Regulatory Fairness Act. This bill was necessary because the 1983 Regulatory Flexibility Act, a small business regulatory relief proposal, was essentially being ignored by most state agencies.

The Small Business Regulatory Fairness Act (Act 145), includes a process to assist agencies and promote greater compliance with the requirements of regulatory flexibility.

Specifically, the Act requires any state agency that proposes or revises a rule that may have an impact on small business to consider methods that will reduce that impact.

The Office of the Insurance Commissioner has concluded this rule will affect just one small business, a Limited Service Health Organization, and according to the initial regulatory flexibility analysis, the rule will not have a significant economic impact on that one insurer.

However, as representatives of the insurance industry have/will testify, this rule proposal may have an impact on the cost of health coverage for those firms enrolled in a PPO plan.

That potential cost impact for small business is what brings me to the hearing this afternoon. More than a third of our members are enrolled in a PPO plan – no other type of coverage is even close to the popularity of PPOs. Historically, PPO plans have satisfied consumer demands for lower cost health coverage options along with greater choice of health care providers.

Although the Insurance Commissioner analysis concludes the rule will not impact a significant number of small businesses, we disagree.

If 32 percent or 4000 of our members are enrolled in a PPO plan, and these firms employ, on average, ten workers, that means 40,000 people will be impacted by any revision in the law or regulatory process that will effect the cost of PPO plans.

The Small Business Regulatory Fairness Act requires the referral of any rule that may have a significant economic impact on small business to the Small Business Regulatory Review Board.

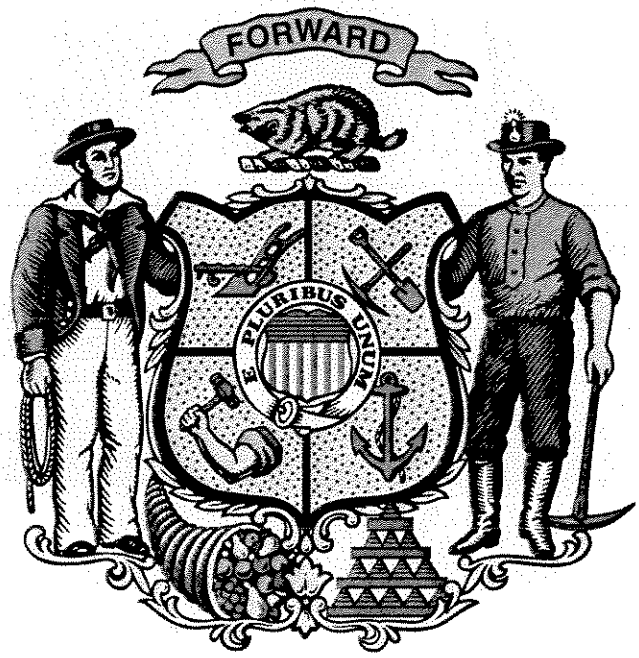
I am not here to speak on the merits of this rule proposal, and my testimony should not be interpreted as opposition to content or intent of the Commissioner in proposing the rule. That debate can occur among others. We are here on the issue of process.

We recognize one may conclude the revisions to Ins. 9 may not have a direct impact on small business, however, we believe it is good public policy and consistent with the spirit of small business regulatory flexibility to perform the analysis even when the regulation has an indirect impact.

We believe the rule will have both a direct and indirect impact on thousands of small business owners – some who sell and some who purchase PPO plans.

Accordingly, we request the rule be returned to the Office of the Commissioner of Insurance. A small business impact analysis can be prepared, and submitted to the Small Business Regulatory Review Board, which will make a determination whether the rule has been properly reviewed and analyzed for it's impact on small business.

Thank you.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W.A.L.H.I.

Wisconsin Association of Life & Health Insurers

Memorandum

American Family Life Insurance Company

American Medical Security

Blue Cross & Blue Shield United Of Wisconsin

Catholic Knights

CUNA Mutual Group

Equitable Reserve Association

Fortis Health

Humana Insurance Company

Midwest Security Life Insurance Company

Northwestern Mutual

The Old Line Life Insurance Company of America

Thrivent Financial For Lutherans

WEA Trust

Wisconsin Auto & Truck Dealers Insurance Corporation

WPS Health Insurance

DATE: October 13, 2005
TO: Committee Chairs and Members of the Senate and Assembly Insurance Committees
FROM: Pat Osborne, on behalf of the Wisconsin Association of Life & Health Insurers (WALHI)
RE: Comments on Clearinghouse Rule 05-059

The Wisconsin Association of Life and Health Insurers (WALHI) appreciates the opportunity to provide comment on OCI proposed rules relating to defined network plans and preferred provider plans. We would first like to recognize and commend the Commissioner and his staff for the process and the hard work that went into the development of this rule package. WALHI and its member companies participated in numerous working sessions conducted by the Commissioner in an attempt to clarify issues and narrow policy differences. We believe the working sessions were productive in that regard and resulted in a draft rule before you today that is considerably improved over the discussion draft issued by OCI in October of 2004.

I am appearing today neither for or against the proposed rule. WALHI is a trade association comprised of numerous companies with diverse business operations and, despite improvements in the rule, not all member companies are satisfied with all of the provisions. I anticipate you will hear from individual member companies regarding their respective positions on the rule.

There is one issue I would like to briefly comment on from an association perspective. That issue pertains to provider contracting and is covered under Ins 9.32 (2) (c) through (f), which requires an insurer offering a preferred provider plan to include in all participating provider contracts a clause requiring the provider to disclose, to the enrollee, whether nonparticipating providers may be involved in the delivery of care. We support the concept of this provision and recognize that it represents a compromise in comparison to a more onerous approach contained in OCI's October 20, 2004 discussion draft rule. However, we believe that the ancillary provider issue is better addressed through a statutory change rather than a contracting requirement in the administrative code. From our perspective, such statute should require not only the disclosure of ancillary health care providers, but should also ensure that enrollees are provided with a good-faith, timely estimate of charges.

Thank you for your consideration.

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