WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Ronald Sklansky
Clearinghouse Director

Terry C. Anderson
Legislative Council Director

Richard Sweet
Clearinghouse Assistant Director

Laura D. Rose
Legislative Council Deputy Director

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".)