WISCONSIN LEGISLATIVE COUNCIL
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CLEARINGHOUSE RULE 05-059

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 January 2005.]

2. Form, Style and Placement in Administrative Code

a. SECTION 1 renumbers many paragraphs in s. Ins 3.67 (1). It would cause less disruption if renumbering were minimized by simply renumbering (e) to (a) and (a) to (am). Also, ", as renumbered," should be inserted preceding the last reference to "s. 3.67 (1) (a)" in the treatment clause. Both comments also apply to SECTIONS 5 and 11. (For example, in SECTION 5, the only renumbering necessary is renumbering (12) to (3m).)

b. The treatment clause in SECTION 2 should refer only to s. Ins 3.67 (4) (intro.) as that is all that is being amended.

c. In s. Ins 3.67 (4), the notation "sub." should be replaced by "subs." and the reference to "s. 18.03" should be changed to "s. Ins 18.03." [s. 1.07 (2), Manual.]

d. When a rule is amended, language to be removed is stricken-through and new material is underscored. The new underscored material always immediately ***follows*** the over-stricken material. [See s. 1.06 (1), Manual.] The rule has many examples of failure to follow this protocol, including: ss. Ins 9.01 (3), 9.07 (1), 9.30 (intro.), 9.31 (2) (intro.), 9.35 (1) (intro.), (a) 1., 2., and 3., and (b) 1., (2) (intro.), and (3) (intro.), 9.36 (1) and (2), 9.38 (4) (c), 9.40 (4), 9.42 (1), and 9.42 (5) (a). The entire rule should be carefully reviewed for this problem.

e. In s. Ins 9.01 (9m), (10m), and (14m), the phrase ", for purposes of this chapter," should be deleted as s. Ins 9.01 (intro.) already makes clear that the definitions apply for ch. Ins 9.

f. In s. Ins 9.01 (13), "~~plan preferred provider plan or limited service health organization~~" should be deleted. That language is not in the current rule and should not be shown as material that is being removed. [See s. 1.06 (1), Manual.] The same comment applies to the following: "~~directly or indirectly~~" in s. Ins 9.01 (15); the second use of "~~s. 609.01 (4), Stats.,~~" in s. Ins 9.01 (15); "~~utilization management requirement, including a preauthorization requirement, is a referral if the utilization management provision is applied in a discriminatory manner so as to favor participating providers~~" in s. Ins 9.01 (15); and "~~2006~~" in both s. Ins 9.40 (6) and (7). Section Ins 9.07 (1) should be reviewed for similar problems.

g. In the first sentence of s. Ins 9.01 (15), the comma following "Stats.", and the word "and" should also be shown as underlined as they are being inserted. [See s. 1.06 , Manual.]

h. In s. Ins 9.01 (15), the definition of "preferred provider plan" is being amplified beyond its meaning in s. 609.01 (4), Stats., with substantive provisions being included as to the consequences that will apply if a preferred provider plan takes certain actions. Substantive provisions cannot be incorporated as part of a definition. [s. 1.01 (7) (b), Manual.]

i. SECTION 10 should simply indicate that s. Ins 9.30 is repealed. The language should not be included as over-stricken. [s. 1.06 (1), Manual.]

j. If the treatment clause indicates that a provision is being amended, all of that provision should be shown, even the portions that are not being changed. Alternatively, the treatment clause may refer only to those provisions that are being amended.

For example, in SECTION 11, the treatment clause could indicate that "9.31 and 9.32 are renumbered 9.30 and 9.31 and, as renumbered, s. 9.30 (intro.) and 9.31 (1) (intro.) and (2) (intro.), (a), and (d) are amended to read:". Otherwise, all of these two sections should be shown, even the parts that are not changed. (As noted above, it is not necessary to renumber these provisions.)

Similarly, SECTION 14 indicates that s. Ins 9.37 is being amended, but only parts of s. 9.37 are produced in the proposed order. (In particular, most of s. 9.37 (1) is not reproduced.)

k. In ss. Ins 9.32 and 9.33, the titles to the sections should be shown with an initial capital letter and in bold print. [s. 1.05 (2) (b), Manual.]

l. In ss. Ins 9.325 and 9.34, titles to the sections should be included. [s. 1.05 (1), Manual.]

m. In s. Ins 9.325, the two references to "Stat." should be changed to "Stats."

n. Section Ins 9.33 should not create sub. (1) inasmuch as there are no other subsections. [s. 1.03 (intro.), Manual.] It appears that sub. (1) (a) should be sub. (1) and that sub. (1) (b) should be sub. (2). (Further, the title to sub. (1) is shown in the incorrect type style.) [s. 1.05 (2) (c), Manual.]

o. The note in s. Ins 9.33 referring to the forms should indicate that the forms can be obtained at no charge. Also, if the forms are available on the Internet, the note should indicate the website. [s. 1.09 (2), Manual.]

p. In ss. Ins 9.32 (1) (a) 1., (b) 1., (c) 1., and (d) 1., and 9.34 (1) (e) 1. should end with a period, rather than a semicolon or the word "or." [s. 1.03 (intro.), Manual.]

q. In s. Ins 9.34 (2), the structure of par. (f) is not consistent with the new structure of the remaining paragraphs. A new subsection should be created.

r. In SECTION 17, the language in s. Ins 9.40 (1) (intro.) [(1) In this section:] should not be included as it is not affected. Also, s. Ins 9.40 (1) (c) should be repealed in a separate section.

s. In s. Ins 9.42 (1), "organizations" is shown as both underscored and over-stricken. It should be shown as over-stricken. Also, it should be changed to "~~organization~~" as that is the term used in the current rule that is being removed. [s. 1.06 (1), Manual.]

t. In s. Ins 9.42 (4) (intro.), "shall:" should be changed to "shall do all of the following:" to make the relationship of the subsequent paragraphs clear. [s. 1.03 (8), Manual.]

u. The treatment clause in SECTION 21 should specify that it is Appendix D to ch. Ins 9. Also, in the Appendix, it is not necessary to include the word "(title.)."

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

a. In Item 3. of the Analysis, the notation "s." should be replaced by the notation "ss."

b. In the treatment clause in SECTION 1, the reference to "3.67 (1) (a) and (d) are amended" should be changed to "3.67 (1) (a) and (c) are amended."

c. Section Ins 9.32 (1) (d) provides an exception to the requirements in s. Ins 9.32 (1) (b) and (c). Thus, s. Ins 9.32 (1) (b) and (c) should include qualifying language such as: "Except as provided in par. (d), …."

d. Section Ins 9.32 (2) specifies that an insurer offering a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when performed by a participating provider is subject to the requirements of several statutes, namely, ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), Stats., and also the requirements of s. Ins 9.34 (1) (a) and (2) (a). (In the cross-reference, the word "and" should be inserted before "9.40" and the notation "s." should be replaced by the notation "ss.")

It would be useful to include cross-references to other provisions in ch. Ins 9 that must be complied with that interpret ss. 609.22 (2), (3), (4), and (7), 609.32 (1), and 609.34 (1), Stats., which appear to include ss. Ins 9.34 (1) (b) and (c), 9.37 (4), and 9.40 (2). Also, should s. Ins 9.34 (2) (a) be included as a requirement if s. Ins 9.34 (1) (a) is cited as a cross-reference in s. Ins. 9.32 (2).

e. Section Ins 9.33 (1) (a) refers to certifying compliance with the access standards "of this section." However, no access standards are specified in s. Ins 9.33. The correct reference should be substituted.

Also, s. Ins 9.33 (1) (a) requires certification, from a defined network plan that is not a preferred provider plan, of compliance with s. 609.22, Stats., and with "s. Ins 9.34, if applicable." It appears that s. Ins 9.34 (1) will always be applicable; thus, this more specific cross-reference should be provided, and the phrase "if applicable" should be deleted.

f. Section Ins 9.33 (1) (b) requires certification, from a defined network plan offering a preferred provider plan, of compliance with specified subsections of s. 609.22, Stats., and with s. Ins 9.34 "if applicable." It appears that s. Ins 9.34 (2) will be applicable; thus, the reference to "if applicable" is confusing. It also appears that, under s. 609.35, Stats., the remaining subsections of s. 609.22, Stats., and s. Ins 9.34 (1) will also be applicable if the preferred provider plan does not cover the same services when performed by a nonparticipating provider that it covers when performed by a participating provider. This should be made clearer, for example, by requiring certification of compliance with these provisions also (for example, by cross-referencing the requirements in s. Ins 9.32 (2)).

g. Finally in s. Ins 9.33 (1) (b), "ss." should be changed to "s." since only one section is cited.

h. In s. Ins 9.34 (2) (e) 1. and 2., the notation "sub." should be replaced by the notation "par."

i. Section Ins 9.38 (4) (c) refers to "subsection 9.34 (2) (a) 4." The cross-reference is incorrect as there is no such provision. (If there were, the correct format would be to refer to "s. Ins 9.34 (2) (a) 4.") [See s. 1.07 (2), Manual.]

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

a. The third paragraph of Item 5. of the Analysis indicates that if a preferred provider plan engages in certain behaviors, the preferred provider plan will be treated by the Commissioner of Insurance (Commissioner) as a defined network plan and be subject to all requirements of a defined network plan. Also, the fourth paragraph describes the differences between regulation of defined network plans and preferred provider plans, for example, implying that all defined network plans must comply with the items specified. However, most of the items specified apply to only a subset of defined network plans, that is, those that are not preferred provider plans and those that are preferred provider plans but do not cover the same services when performed by a nonparticipating provider that are covered when performed by a participating provider.

It is confusing to indicate that such a preferred provider plan will be treated as a defined network plan because, under the statutory definitions, most (but not all) preferred provider plans are defined network plans. It would appear to be more useful to explain that the statutes: (1) impose certain requirements on all defined network plans; (2) impose other requirements on

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.); and (3) under s. 609.35, Stats, also impose the requirements listed in item (2) on preferred provider plans that do not cover the same services when performed by a nonparticipating provider that are covered when performed by a participating provider.

A similar comment applies to s. Ins 9.01 (15), defining "preferred provider plan" and indicating that a preferred provider plan that takes certain actions "is subject to all requirements of a defined network plans[sic]." A similar comment applies to s. Ins 9.32 (2) (intro.), which indicates that an insurer offering a preferred provider plan that does not cover the same services when performed by a nonparticipating provider that it covers when performed by a nonparticipating provider "is subject to the requirements of a defined network plan…." Again, these provisions do not appropriately distinguish between the types of defined network plans.

b. In the last sentence of the second paragraph of Item 5. of the Analysis, the word "meeting" should be replaced by the word "meetings."

c. In the second sentence of the sixth paragraph of Item 5. of the Analysis, the word "to" should be inserted after the word "compared."

d. In the last sentence of the ninth paragraph of Item 5. of the Analysis, "insurer comply" should be changed to "insurer complies" and the last comma should be replaced by the word "and."

e. In the first sentence of the 10th paragraph of Item 5. of the Analysis, "non-emergent" should be changed to "non-emergency."

f. In the second sentence of the 13th paragraph of Item 5. of the Analysis, the word "hour's" should be replaced by the word "hours." In the last sentence of this paragraph, commas should be inserted after the words "operation" and "appointments."

g. In the last sentence of the last paragraph of Item 5. of the Analysis, "amply time" should be changed to "ample time."

h. In the first paragraph of the Illinois comparison in Item 7. of the Analysis, "requires health care plan" should be changed to "requires a health care plan."

i. In the first sentence of the second paragraph of the Illinois comparison in Item 7. of the Analysis, "are" should be changed to "is."

j. In the first sentence of the fourth paragraph of the Illinois comparison in Item 7. of the Analysis, "requires health" should be changed to "requires that health."

k. The last sentence of the second paragraph of the Minnesota comparison in Item 7. of the Analysis, should be changed to make it grammatically correct.

l. In the first sentence of the first paragraph of the Michigan comparison in Item 7. of the Analysis, "requires . . . shall provide" should be changed to "requires . . . to provide." Also, "services provide" should be changed to "services provided."

m. In the first sentence of the last paragraph of Item 8. of the Analysis, "In addition the complaint review" should be changed to "In addition to the complaint review." Also, in the fourth sentence, the word "representative" should be replaced by the word "representatives."

n. In the first paragraph of Item 9. of the Analysis, it would be useful to explain that the Commissioner has authorized one LSHO to write up to 10% of its premium as a preferred provider plan. This could be done by changing the phrase "and authorized to only write 10%" to "that has been authorized by the Commissioner to write up to 10%." In the last sentence of the last paragraph of Item 9., the word "affect" should be replaced by the word "effect."

o. In the last sentence of the first paragraph of Item 11. of the Analysis, "stated in above" should be changed to "stated above."

p. In s. Ins 9.01 (3), "to the insurer" should be changed to "to an insurer." Also, "about an insurer" should be changed to "about the insurer."

q. In s. Ins 9.01 (6), a comma should be inserted after the word "plan."

r. Should the definition of "intermediate entity" in s. Ins 9.01 (9m) also refer to enrollees of a preferred provider plan in order to acknowledge the subset of preferred provider plans that are not defined network plans? Also, should LSHOs be included to apply to those that cover services other than dental or vision? Finally, the word "a" should be inserted before the third occurrence of the word "provider."

s. In s. Ins 9.01 (10m), it appears that "limited scope plan" should be defined as a plan offered by an insurer that provides certain benefits, rather than referring to the plan as the insurer.

t. In s. Ins 9.01 (15), the definition of "preferred provider plan" is being amplified beyond its meaning in s. 609.01 (4), Stats., including the statement that if a preferred provider plan uses utilization management for denying access to coverage of the services of nonparticipating providers without "just cause" and with "such frequency as to indicate a general business practice," the Commissioner will treat the plan as a defined network plan subject to all requirements of a defined network plan.

As noted above, such substance cannot be included in a definition. Moreover, the rule does not specify how, on what basis, and by whom a determination is made that there is not "just cause" or when there is "such frequency as to indicate a general business practice" in order to trigger this consequence.

Also, the last word in the definition should be "plan," not "plans."

u. In s. Ins 9.07 (1), the first occurrence of the word "a" should be deleted.

v. The rule is inconsistent by sometimes referring to insurers (or an insurer) offering defined network plans and sometimes referring to insurers (or an insurer) offering a defined network plan. See, for example, ss. Ins 9.30 (intro.), 9.31 (2) (intro.), 9.36, 9.37, and 9.38 (intro.) and (4) (intro.) and (c). If the provisions are intended to apply regardless of whether an

insurer offers only one defined network plan or offers one or more defined network plans, ch. Ins 9 should consistently refer to insurers (or an insurer) offering a defined network plan.

Also, in the first sentence of s. Ins 9.32 (1) (d) (intro.), "a preferred provider plans" should be changed to "a preferred provider plan" or "preferred provider plans."

w. In s. Ins 9.31 (2), the word "and" should be inserted before the notation "ss."

x. In s. 9.32 (1) (a) (intro.), a period should be inserted following "Stats."

y. 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 requirements that are otherwise imposed only on defined network plans that are not preferred provider plans. Section Ins 9.32 (1) provides that, for purposes of s. 609.35, Stats., a preferred provider plan 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 insurer complies with one of two conditions specified in s. Ins 9.32 (1) (a) 1. and 2., which relate to the coinsurance rate.

In contrast, the provisions in s. Ins 9.32 (1) (b) (relating to coinsurance differentials between participating and nonparticipating providers) and in s. Ins 9.32 (1) (c) (relating to deductible differentials between participating and nonparticipating providers) are written as express requirements placed on preferred provider plans that have no express connection to the concept of covering the same services for purposes of s. 609.35, Stats. The following comments apply:

1) A plain language reading of the statutes suggests that "cover[ing]" the same services" relates to the concept of comparing how participating and nonparticipating providers are dealt with by the insurer. This does not occur in s. Ins 9.32 (1) (a), but does occur in both s. Ins 9.32 (1) (b) and (c). However, it is only s. Ins 9.32 (1) (a) that is specified as providing the test for covering the same services.

2) Section Ins 9.32 (1) (b) and (c) are requirements placed on preferred provider plans. It would be useful to more clearly specify the consequences if there is not compliance. (For example, for noncompliance with s. Ins 9.32 (1) (a), the consequences are specified in s. Ins 9.32 (2).)

3) Because some plans have copayments for certain services, rather than coinsurance, is a significant differential in copayments between participating and nonparticipating providers considered to be covering the same services?

4) The proposed definition of "preferred provider plan" in s. Ins 9.01 (15) indicates that if the insurer offering the preferred provider plan engages in certain behaviors relating to access to care by a nonparticipating provider, the preferred

provider plan will be subject to all requirements of a defined network plan. It appears that these behaviors relate to the concept of "covering the same services." If so, it is not clear why they are not included in s. Ins 9.32 (1).

z. Section Ins 9.32 (1) (b) (intro.) and (c) (intro.) both require an insurer to "***do*** either of the following." [Emphasis added.] Thus, s. Ins 9.32 (1) (b) 1. and 2. and (c) 1. and 2. should both describe some action to be taken. However, neither do. Either the introductory language should be changed to refer to offering plans that have one of those characteristics or the action to be taken should be included in the subdivisions.

aa. Section Ins 9.32 (1) (a) 2. refers to providing the enrollee with "the disclosure notice in sub. (3)." In contrast, s. 9.32 (1) (b) 2. and (c) 2. refer to providing the enrollee with "a disclosure notice that is compliant with sub. (3)." Was a difference intended? If not, ambiguity would be decreased by selecting one phrase and using it consistently.

bb. In the first sentence of s. Ins 9.32 (1) (d) (intro.), it appears that the conjunction "or" preceding "conditions" should be changed to "and."

cc. Section Ins 9.32 (1) (d) permits an insurer to make exceptions to coinsurance and deductible differentials in s. Ins 9.32 (1) (b) or (c) to the extent "reasonably necessary" to encourage enrollees to use "participating providers or centers of excellence for transplant or other unique disease treatment services, preventive health care services limited to immunizations pursuant to s. 632.895 (14), Stats., and services as covered benefits greater than minimum required for specific mandated benefits under ss. 632.895 and 632.89, Stats." when the insurer makes certain disclosures. The following comments apply:

1) 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."

2) It is not clear why the phrase "preventive health services limited to" is necessary. It appears that reference to "immunizations pursuant to s. 632.895 (14), Stats.," would be sufficient.

3) "Than minimum" should be changed to "than the minimum."

4) "s. 632.895 and 632.89" should be changed to "ss. 632.895 and 632.89."

dd. In s. Ins 9.32 (1) (d) 1., "benefits are" should be changed to "benefits that are."

ee. In s. Ins 9.32 (1) (d) 2., "covered when" should be changed to "covered only when." Also, "disparity in than" should be changed to "disparity than."

ff. Section Ins 9.32 (1) (e) is a partial sentence. Since there is no s. Ins 9.32 (1) (intro.) providing introductory language, this paragraph should be revised to be a free-standing complete sentence.

gg. In s. Ins 9.32 (3), it is noted that the disclosure must be provided at the time of solicitation and in the certificate of coverage under a group policy and in an individual policy. In

contrast, a different notice referred to in s. Ins 9.32 (1) (d) must be provided at the point of sale and within the policy. Should s. Ins 9.32 (1) (d) refer to a certificate under a group policy? Also, was the distinction between time of solicitation and time of sale intended?

hh. Section Ins 9.32 (3) includes the text of a notice to be provided about limited benefits that will be paid when nonparticipating providers are used. It makes no mention that the terms specified in the notice do not apply in emergency situations, even though s. Ins 9.34 (1) (d) provides that that is the case. It appears that the notice should comment on this to be consistent with s. Ins 9.34 (1) (d).

ii. In the highlighted sentence in the notice under s. Ins 9.32 (3), "COINSURNACE" is misspelled. Also, in that notice, the references to "members" and "member" are confusing; it appears that the references should be changed to the defined term "enrollee."

jj. Sections Ins 9.32 (4) and 9.33 (1) (a) and (b) refer to an "insurer." They also refer to the "company." If these are one and the same, a consistent term should be used to avoid ambiguity.

kk. Section Ins 9.33 (1) (b) requires insurers offering a preferred provider plan to file a certification within three months after the effective date of that section, with the Revisor of Statutes to insert the date. SECTION 23 provides an effective date of the first day of the first month following publication. However, SECTION 24 provides that the rule first applies to newly issued policies on January 1, 2007 and to renewing policies on January 1, 2008. What is the purpose and effect of the delayed applicability date? Which provisions of the rule are affected by the applicability date?

ll. In the last sentence of s. Ins 9.34 (1) (d) and in s. Ins 9.34 (2) (e) (intro.), (f), and (g), it may be useful to specifically refer to coinsurance as that term is prominently used in other parts of ch. Ins 9.

mm. In s. Ins 9.34 (2) (b), it appears that "that" should be changed to "to."

nn. In s. Ins 9.34 (2) (c) and (e), "non-emergent" should be changed to "non-emergency."

oo. Section Ins 9.37 (4) does not make clear how, on what basis, and by whom, a determination is made that there is not "just cause" or that there is "such frequency as to indicate a general business practice."

pp. Section Ins 9.40 (2) (a) and (b) are inconsistent. Section Ins 9.40 (2) (a) imposes certain requirements, as of April 1, 2000, on insurers with respect to a defined network plan that is not a preferred provider plan. Section Ins 9.40 (2) (b) indicates that insurers offering defined network plans that are not preferred provider plans or health maintenance organizations must comply with s. Ins 9.40 (2) (a) by April 1, 2007. However, the plans in s. Ins 9.40 (2) (b) are a subset of those described in s. Ins 9.40 (2) (a), which creates an inconsistency between the provisions. It appears that s. Ins 9.40 (2) (a) would have to include the phrase "except as provided in par. (b)" to remedy this inconsistency.

qq. Section Ins 9.40 (2) (b), (6), and (7) impose certain requirements on insurers offering defined network plans that are not preferred provider plans or health maintenance organization plans. In the case of s. Ins 9.40 (2) (b), they are required to begin annually submitting a quality assurance plan April 1, 2007; in the case of s. Ins 9.40 (6), they are to begin annually submitting standardized data sets by June 1, 2008; and in the case of s. Ins 9.40 (7), they are required to include certain information about quality assurance plans in materials by April 1, 2008.

The Analysis does not explain that such plans are uniquely affected by the rule. It would be helpful if the Analysis explained the type of entity included in this category and describe the special provisions applicable to them.

rr. In the next-to-last sentence of s. Ins 9.42 (1), it appears that "network and limited" should be changed to "network or limited" to be consistent with the first sentence in that subsection.

ss. Section Ins 9.42 (9) indicates that an insurer offering a preferred provider plan that is not a defined network plan must comply with s. Ins 9.42 "to the extent applicable." This does not provide sufficient information to determine which other provisions are applicable. To the extent those other provisions make clear that they are applicable, s. Ins 9.42 (9) is not needed.

tt. In SECTION 22, the comma should be deleted in the treatment clause.

uu. In s. Ins 18.03 (2) (c) 1., a space should be inserted between "in" and "s."