State of Wisconsin
2005 - 2006 LEGISLATURE

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2005 SENATE BILL 687

April 11, 2006 - Introduced by JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES. Referred to Committee on Agriculture and Insurance.

AN ACT ***to renumber*** 609.35; and ***to create*** 609.20 (3), 609.21 and 609.35 (2) of the statutes; **relating to:** prohibiting the Office of the Commissioner of Insurance from promulgating certain rules related to limited-scope dental or vision plans and preferred provider plans.

Analysis by the Legislative Reference Bureau

Current law contains various provisions that apply specifically to defined network plans and preferred provider plans, including one chapter that deals primarily with those plans. A defined network plan is a hospital or medical policy or certificate that requires, or provides incentives for, enrollees to obtain health care services from providers that are managed, owned, under contract with, or employed by the insurer offering the policy or certificate (participating providers). Limited-scope dental or vision plans, however, are specifically excluded, as are certain other types of plans. A health maintenance organization is an example of a defined network plan. Except for a type of preferred provider plan that is specifically excluded from the description of a defined network plan, such as a limited-scope dental or vision plan, a preferred provider plan, which covers either comprehensive or limited health care services provided by either participating or nonparticipating providers, is also a defined network plan because obtaining services from participating providers usually requires lower levels of cost-sharing than obtaining services from nonparticipating providers. This bill prohibits the commissioner of insurance (commissioner) from promulgating, under the chapter of the statutes that deals primarily with defined network plans and preferred provider plans, rules

relating to limited–scope dental or vision plans. The bill also prohibits the commissioner from promulgating rules that impose certain specific requirements on preferred provider plans.

The bill is introduced as required by s. 227.26 (2) (f), stats., in support of the action of the Joint Committee for Review of Administrative Rules in suspending, on March 1, 2006, all of the following rules of the Office of the Commissioner of Insurance:

1. Section Ins 9.01 (10m), Wis. Adm. Code.

2. Portions of ss. Ins 9.01 (5), (9m), and (13), 9.07 (1), 9.20 (intro.), 9.32 (2) (a), 9.33, 9.41, and 9.42 (1) and (5) (a), Wis. Adm. Code.

3. Section Ins 9.25 (4), Wis. Adm. Code.

4. Section Ins 9.32 (2) (c), (e) 1., and (f), Wis. Adm. Code.

Some of the suspended rules related to limited–scope dental and vision plans. The remainder of the suspended rules imposed requirements on preferred provider plans related to: 1) requiring participating providers to disclose all providers who would be involved in a procedure and whether each provider is a participating or nonparticipating provider; 2) coverage of, and payment rates for, emergency medical services rendered by nonparticipating providers in certain circumstances; 3) treating a preferred provider plan as a defined network plan on the basis of its use of utilization management for denying access to nonparticipating providers; and 4) the provision of covered benefits with respect to hours of operation, waiting times for appointments, and after hours care.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 609.20 (3) of the statutes is created to read:

609.20 **(3)** The commissioner may not promulgate any of the following rules relating to preferred provider plans:

(a) A rule that imposes requirements for the provision of benefits by participating providers with respect to hours of operation, waiting times for appointments in provider offices, and the availability of after hours care.

(b) A rule that requires contracts with participating providers to include a requirement for the provider to disclose to an enrollee, at the time an elective procedure or other nonemergency care is scheduled, the name of each provider that

will or may be involved with providing the care and whether each provider is a participating provider or a nonparticipating provider.

(c) A rule that imposes requirements relating to coverage of emergency services rendered by a nonparticipating provider and the rate at which the insurer offering the preferred provider plan must pay the nonparticipating provider.

(d) Any rule that relates to, references, or is contingent upon any requirement prohibited under pars. (a) to (c).

SECTION 2. 609.21 of the statutes is created to read:

609.21 Rules for limited–scope plans prohibited. The commissioner may not promulgate a rule under this chapter that relates to a health care plan that provides limited–scope dental or vision benefits under a separate policy, certificate, or contract of insurance, as described in s. 609.01 (1g) (b) 9.

SECTION 3. 609.35 of the statutes is renumbered 609.35 (1).

SECTION 4. 609.35 (2) of the statutes is created to read:

609.35 **(2)** The commissioner may not promulgate a rule that subjects a preferred provider plan to the requirements specified in sub. (1) on the basis of the utilization management practices of the insurer offering the preferred provider plan, including the use of utilization management to deny access to or coverage of services of nonparticipating providers.

(END)