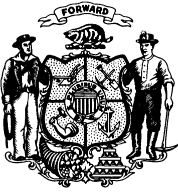

State of Wisconsin
2017 - 2018 LEGISLATURE

LRB-5551/1
TJD:amn&ahe

2017 SENATE BILL 842

February 21, 2018 - Introduced by Senators VINEHOUT, RISSER and LARSON, cosponsored by Representatives ANDERSON, BILLINGS, BERCEAU, ZAMARRIPA, SARGENT, SPREITZER, SINICKI, SUBECK, BROSTOFF and POPE. Referred to Committee on Insurance, Financial Services, Constitution and Federalism.

1 AN ACT ***to create*** 609.048 of the statutes; **relating to:** evaluation of health plan
2 network adequacy.

Analysis by the Legislative Reference Bureau

This bill requires the commissioner of insurance to determine sufficiency of the network of providers of a defined network plan or preferred provider plan. Defined network plans and preferred provider plans are types of managed care organizations that provide health care benefits to their enrollees. The bill allows the commissioner to require a plan to make accomodations for enrollees to obtain covered services if the plan's network is not sufficient. The bill also specifies factors that the commissioner is allowed to consider when considering whether a plan's network is sufficient.

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:

3 **SECTION 1.** 609.048 of the statutes is created to read:

4 **609.048 Network adequacy.** The commissioner shall determine sufficiency
5 of the defined network plan's or preferred provider plan's network to ensure that all
6 covered services are accessible to enrollees without unreasonable travel or delay.

1 The commissioner may require a defined network plan or preferred provider plan to
2 make accommodations for enrollees to obtain covered services if its network is not
3 sufficient. Factors the commissioner may consider when considering network
4 sufficiency may include any of the following:

5 **(1)** The ratio of primary care providers to enrollees.

6 **(2)** The geographic accessibility of providers.

7 **(3)** The waiting time for an appointment with a provider of a particular
8 specialty who is in the network.

9 **(4)** The ability of the network to meet the needs of the population of enrollees.

10 **(5)** The extent to which providers in the network are accepting new patients.

11 **(6)** Whether the plan has a process of ensuring that an enrollee is able to obtain
12 a covered service at an out-of-pocket cost that is the same as for a service provided
13 by a provider in the network if a provider in the network is not available to provide
14 the covered services without unreasonable travel or delay.

15 **(END)**