CHAPTER 609

HEALTH MAINTENANCE ORGANIZATIONS, LIMITED SERVICE HEALTH ORGANIZATIONS AND PREFERRED PROVIDER PLANS

NOTE: See note following s. 609.60 prepared by the commissioner of insurance concerning provisions of chs. 600 to 655 that apply to organizations under ch. 609.

609.001 Joint ventures; legislative findings. (1) The legislature finds that increased development of health maintenance organizations, preferred provider plans and limited service health organizations may have the effect of putting small, independent health care providers at a competitive disadvantage with larger health care providers. In order to avoid monopolistic situations and to provide competitive alternatives, it may be necessary for those small, independent health care providers to form joint ventures. The legislature finds that these joint ventures are a desirable means of health care cost containment to the extent that they increase the number of entities with which a health maintenance organization, preferred provider plan or limited service health organization may choose to contract and to the extent that the joint ventures do not violate state or federal antitrust laws.

(2) The legislature finds that competition in the health care market will be enhanced by allowing employers and organizations which otherwise act independently to join together in a manner consistent with the state and federal antitrust laws for the purpose of purchasing health care coverage for employes and members. These joint ventures will allow purchasers of health care coverage to obtain volume discounts when they negotiate with insurers and health care providers. These joint ventures should result in an improved business climate in this state because of reduced costs for health care coverage.

History: 1985 a. 29.

609.01 Definitions. In this chapter:

(1) "Health care plan" has the meaning given under s. 628.36 (2) (a) 1.

(2) "Health maintenance organization" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

(3) "Limited service health organization" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined periodic fixed payments, a limited range of health care services performed by providers selected by the organization.

(4) "Preferred provider plan" means a health care plan offered by an organization established under ch. 185, 611, 613 or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, for consideration other than predetermined periodic fixed payments, either comprehensive health care services or a limited range of health care services performed by providers selected by the organization.

(5) "Primary provider" means a selected provider who is an individual and who is designated by an enrolled participant.

(6) "Selected provider" means a provider, as defined in s. 628.36 (2) (a) 2, selected by a health maintenance organization, limited service health organization or preferred provider plan to perform health care services for enrolled participants.

(7) "Standard plan" means a health care plan other than a health maintenance organization or a preferred provider plan.

History: 1985 a. 29.

609.05 Primary provider and referrals. (1) Except as provided in subs. (2) and (3), a health maintenance organization, limited service health organization or preferred provider plan shall permit its enrolled participants to choose freely among selected providers.

(2) A health care plan under sub. (1) may require an enrolled participant to designate a primary provider and to obtain health care services from the primary provider when reasonably possible.

(3) Except as provided in s. 609.65, a health care plan under sub. (1) may require an enrolled participant to obtain a referral from the primary provider designated under sub. (2) to another selected provider prior to obtaining health care services from the other selected provider.

History: 1985 a. 29; 1987 a. 366.

609.10 Standard plan required. (1) (a) Except as provided in subs. (2) to (4), an employer that offers any of its employes a health maintenance organization or a preferred provider plan that provides comprehensive health care services shall also offer the employes a standard plan, as provided in pars. (b) and (c), that provides at least substantially equivalent coverage of health care expenses and that is not a health maintenance organization or a preferred provider plan.

(b) At least once annually, the employer shall provide the employes the opportunity to enroll in the health care plans under par. (a).

(c) The employer shall provide the employes adequate notice of the opportunity to enroll in the health care plans under par. (a) and shall provide the employes complete and understandable information concerning the differences between the health maintenance organization or preferred provider plan and the standard plan.

(2) If, after providing an opportunity to enroll under sub. (1) (b) and the notice and information under sub. (1) (c), fewer than 25 employes indicate that they wish to enroll in the standard plan under sub. (1) (a), the employer need not offer the standard plan on that occasion.

(3) Subsection (1) does not apply to an employer that employs fewer than 25 full-time employes.

(4) Nothing in sub. (1) requires an employer to offer a particular health care plan to an employe if the health care plan determines that the employe does not meet reasonable medical underwriting standards of the health care plan.

(5) The commissioner may establish by rule standards in addition to those established under s. 609.20 for what constitutes adequate notice and complete and understandable information under sub. (1) (c).

History: 1985 a. 29.

609.15 Grievance procedure. (1) Each health maintenance organization, limited service health organization and preferred provider plan shall do all of the following:

(a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. (2) for the resolution of enrolled participants' grievances with the health care plan.

(b) Provide enrolled participants with complete and understandable information describing the internal grievance procedure under par. (a).

(c) Submit an annual report to the commissioner describing the internal grievance procedure under par. (a) and summarizing the experience under the procedure for the year.

(2) The internal grievance procedure established under sub. (1) (a) shall include all of the following elements:

(a) The opportunity for an enrolled participant to submit a written grievance in any form.

(b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one enrolled participant other than the grievant, if an enrolled participant is available to serve on the grievance panel.

(c) Prompt investigation of each grievance submitted under par. (a).

(d) Notification to each grievant of the disposition of his or her grievance and of any corrective action taken on the grievance.

(e) Retention of records pertaining to each grievance for at least 3 years after the date of notification under par. (d).

History: 1985 a. 29.

609.17 Reports of disciplinary action. Every health maintenance organization, limited service health organization and preferred provider plan shall notify the medical examining board of any disciplinary action taken against a selected provider who holds a license or certificate granted by the board.

History: 1985 a. 340.

609.20 Rules for preferred provider plans. The commissioner shall promulgate rules applicable to preferred provider plans for all of the following purposes:

(1) To ensure that enrolled participants are not forced to travel excessive distances to receive health care services.

(2) To ensure that the continuity of patient care for enrolled participants is not disrupted.

(3) To define substantially equivalent coverage of health care expenses for purposes of s. 609.10 (1) (a).

(4) To ensure that employes offered a preferred provider plan that provides comprehensive services under s. 609.10 (1) (a) are given adequate notice of the opportunity to enroll and complete and understandable information under s. 609.10 (1) (c) concerning the differences between the preferred provider plan and the standard plan, including differences between providers available and differences resulting from special limitations or requirements imposed by an institutional provider because of its affiliation with a religious organization.

History: 1985 a. 29.

609.60 Optometric coverage. Health maintenance organizations and preferred provider plans are subject to s. 632.87 (2m).

History: 1985 a. 29.

609.65 Coverage for court-ordered services for the mentally ill. (1) If an enrolled participant of a health maintenance organization, limited service health organization or preferred provider plan is examined, evaluated or treated for a nervous or mental disorder pursuant to an emergency detention under s. 51.15, a commitment or a court order under s. 51.20 or 880.33 (4m), then, notwithstanding the limitations regarding selected providers, primary providers and referrals under ss. 609.01 (2) to (4) and 609.05 (3), the health maintenance organization, limited service health organization or preferred provider plan shall do all of the following:

(a) If the provider performing the examination, evaluation or treatment has a provider agreement with the health maintenance organization, limited service health organization or preferred provider plan which covers the provision of that service to the enrolled participant, make the service available to the enrolled participant in accordance with the terms of the health care plan and the provider agreement.

(b) If the provider performing the examination, evaluation or treatment does not have a provider agreement with the health maintenance organization, limited service health organization or preferred provider plan which covers the provision of that service to the enrolled participant, reimburse the provider for the examination, evaluation or treatment of the enrolled participant in an amount not to exceed the maximum reimbursement for the service under the medical assistance program under ss. 49.45 to 49.47, if any of the following applies:

1. The service is provided pursuant to a commitment or a court order, except that reimbursement is not required under this subdivision if the health maintenance organization, limited service health organization or preferred provider plan could have provided the service through a provider with whom it has a provider agreement.

2. The service is provided pursuant to an emergency detention under s. 51.15 or on an emergency basis to a person who is committed under s. 51.20 and the provider notifies the health maintenance organization, limited service health organization or preferred provider plan within 72 hours after the initial provision of the service.

(2) If after receiving notice under sub. (1) (b) 2 the health maintenance organization, limited service health organization or preferred provider plan arranges for services to be provided by a provider with whom it has a provider agreement, the health maintenance organization, limited service health organization or preferred provider plan is not required to reimburse a provider under sub. (1) (b) 2 for any services provided after arrangements are made under this subsection.

(3) A health maintenance organization, limited service health organization or preferred provider plan is only required to make available, or make reimbursement for, an examination, evaluation or treatment under sub. (1) to the extent that the health maintenance organization, limited service health organization or preferred provider plan would have made the medically necessary service available to the enrolled participant or reimbursed the provider for the service if any referrals required under s. 609.05 (3) had been made and the service had been performed by a provider selected by the health maintenance organization, limited service health organization or preferred provider plan.

History: 1987 a. 366.

609.70 Chiropractic coverage. Health maintenance organizations, limited service health organizations and preferred provider plans are subject to s. 632.87 (3).

History: 1987 a. 27.

NOTE: The following note is prepared by the commissioner of insurance as provided in s. 601.21.

Statutes not contained in this chapter that relate to or impose restrictions include, but are not limited to, the following:

I. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, LIMITED SERVICE HEALTH ORGANIZATIONS AND PREFERRED PROVIDER PLANS ORGANIZED UNDER CH. 185.

Insurance - administration:	
Certificate of authority; fee	601.04
Fees	601.31
Examinations and alternatives	601.43
Conducting examinations	601.44
Examination costs	601.45
Domestic and mutual insurance corporations:	
Management contract services	611.67
Risk sharing plans:	
Mandatory health care liability risk sharing plans	619.04
Mandatory health insurance risk sharing plan	Subch. II of Ch. 619
General public policy provisions applicable to insurers and others	Ch. 630
Insurance contracts in specific lines:	
Notice of termination of group hospital, surgical or medical expense insurance coverage due to cessation of business or default of payment of premiums	632.79
Restrictions on health care services - vision care and chiropractic coverage	632.87 (2m) and (3)
Coverage of newborn infants	632.895 (5)
Insurers rehabilitation and liquidation	Ch. 645
Insurance security fund	Ch. 646

II. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, PREFERRED PROVIDER PLANS OR LIMITED SERVICE HEALTH ORGANIZATIONS LICENSED UNDER CHAPTER 611:

Domestic stock and mutual insurance corporations	Ch. 611
Insurance - investments:	
Segregated account investments	620.02
Insurance - accounting and reserves:	
Accounting for repurchased shares	623.34

III. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, PREFERRED PROVIDER PLANS OR LIMITED SERVICE HEALTH ORGANIZATIONS LICENSED UNDER CHAPTER 613:

Service insurance corporations	Ch. 613

IV. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, LIMITED SERVICE HEALTH ORGANIZATIONS AND PREFERRED PROVIDER ORGANIZATIONS LICENSED UNDER CHAPTER 614:

Insurance - fraternals	Ch. 614
Insurance - accounting and reserves:	
Fraternal rates and reserves	623.15
Insurance marketing:	
Licensing of fraternal agents	628.06
Insurance contracts in specific lines:	
Fraternal insurance	Subch. VII of Ch. 632

V. LAWS THAT APPLY ONLY TO HEALTH MAINTENANCE ORGANIZATIONS, LIMITED SERVICE HEALTH ORGANIZATIONS AND PREFERRED PROVIDER ORGANIZATIONS ISSUED A CERTIFICATE OF AUTHORITY UNDER CHAPTER 618:

Insurance - administration:	
Certificate of authority, fee	601.04
Enforcement of policyholder rights	601.71
Nondomestic insurers	Ch. 618

VI. LAWS THAT APPLY TO HEALTH MAINTENANCE ORGANIZATIONS, PREFERRED PROVIDER PLANS OR LIMITED SERVICE HEALTH ORGANIZATIONS ISSUED A CERTIFICATE OF AUTHORITY UNDER CH. 611, 613, 614 or 618:

Insurance - general provisions	Ch. 600
Insurance-administration:	
Purposes	601.01
Definitions	601.02
Fees	601.31
Supervision of industry, supplementary fee	601.32
Reports and replies	601.42
Examinations and alternatives	601.43
Conducting examinations	601.44
Examination costs	601.45
Subchapter V of Ch. 601 - procedures and enforcement	601.61 - 601.73
Insurers in general	Ch. 610, except 610.61
Regulation of insurance holding companies and intercorporate transactions relating to insurers	Ch. 617
Risk sharing plans:	
Mandatory health insurance risk sharing plan	Subch. II of Ch. 619
Insurance - investments	Ch. 620, except 620.02
Insurance - accounting and reserves:	
Applicability	623.01
Standards for accounting rules	623.02
Valuation of assets	623.03
Valuation of liabilities	623.04
Amount of compulsory surplus	623.11
Amount of security surplus	623.12
Adjustment of reserves	623.21
Rate regulation	Ch. 625
Underwriting restrictions	Ch. 627, except 627.15
Insurance marketing	Ch. 628, except 628.05, 628.06 and 628.77
General public policy provisions applicable to insurers and others:	
Political contributions	630.05
Lobbying	630.10
Insurance contracts generally	Ch. 631, except 631.24, 631.37 and 631.69
Assignment of life insurance rights	632.47
Estoppel from medical examination	632.50
Disability insurance	Subch. VI of Ch. 632
Certificate of disability	632.99
Insurers rehabilitation and liquidation	Ch. 645
Insurance security fund	Ch. 646

VII. LAWS THAT APPLY ONLY TO INDIVIDUAL PRACTICE ASSOCIATIONS.

Insurance - administration:	
Definitions	601.42 (1)
Reports	601.42 (1r)
Replies	601.42 (4)