ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING, RENUMBERING, RENUMBERING AND AMENDING, AMENDING, REPEALING AND CREATING AND CREATING A RULE

To repeal s. Ins 9.30, 9.34, 9.42 (1) (c); to renumber s. Ins. 3.67 (1) (a) and (e), 9.31, 9.32; to renumber and amend s. Ins 3.67 (1) (a) and (c), 9.01(12), 9.20 (intro.), 9.21 (1), (2) (intro.), (a) and (d); to amend s. Ins 3.67 (4) (intro.), Chpt. Ins 9 (title), 9.01 (intro.), (3), (5), (13), (15), (17) (intro.), (17) (a) and (c), 9.07 (1), Ins 9 subchpt. III (title), 9.35, 9.36, 9.37 (1) (intro.), (2), (3) and (4), 9.38 (intro.), (4) (intro.) and (c), 9.39 (4), 9.40 (title), (2), (3), (4), (6), (7) (intro.) and (8), 9.42 (1), (2), (3), (4) (intro.), (a) and (e), (5) (a) and (6) (a), 18.03 (2) (c) 1.; and to create s. Ins 9.01 (9m), (10m), (14m), 9.25, 9.26, 9.27, 9.30, 9.32, 9.41, 9.42 (9), and Ins 9 Appendix D, Wis. Adm. Code, relating to revising requirements for insurers offering a defined network plan, preferred provider plan and a limited service health organization plan in order to comply with recent changes in state laws and may affect small businesses.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. Statutes interpreted:

Sections 600.01 (1) (b) 3. cm., 601.01 (1), (2), (3), and (10), Ch. 609 and 632.85, Stats.

2. Statutory authority:

Sections 601.41 (3), 609.20, and 609.38, Stats.

3. Explanation of the OCI's authority to promulgate the proposed rule under these statutes:

The Commissioner of Insurance is authorized to promulgate rules under ss. 601.41 and 609.20, Stats. Section 609.20, Stats., permits the Commissioner to promulgate rules relating to preferred provider plans and defined network plans in order to ensure enrollee access to health care services and ensure continuity of health care while recognizing the differences between preferred provider plans and defined network plans.

4. Related Statutes or rules:

There are no related statutes or rules.

5. The plain language analysis and summary of the proposed rule:

The term "managed care plan" has been replaced with "defined network plan" in ch. 609, Stats., established by 2001 Wisconsin Act 16, therefore, necessitating change within the insurance administrative code. In addition many revisions have been made to ch. Ins 9 to reflect the changes in ch. 609, Stats., including modifications reflecting the unique

nature of preferred provider plans and changes in the market place since 2001 including regulatory changes that enhance consumer protection enacted by surrounding states.

Chapter 609, Stats., through definition of defined network and preferred provider plans, creates a narrow distinction between those types of plans with preferred provider plans being defined as health care plans while defined network plans must meet the definition of a health benefit plan. While most insurers offering preferred provider plans meet the definition of a defined network plan, some insurers do not. Chapter 609, Stats., contains a continuum of requirements with some overlap and some distinction among health plans. For instance, some requirements apply to all insurers offering defined network plans, some requirements apply to insurers offering defined network plans that are not also preferred provider plans and some requirements apply only to insurers offering preferred provider plans or other types of plans including health maintenance or limited service health organizations. The proposed rule continues these distinctions by having some requirements apply to all defined network plans, some requirements apply to defined network plans that are not also preferred provider plans and some apply only to preferred provider plans, health maintenance or limited service health organizations. Within the proposed rule an insurer offering a preferred provider plan that due to changes in benefits or other requirements no longer meets the definition of a preferred provider plan will be described as being subject to the requirements of a defined network plan even if the insurer offering the preferred provider plan could meet both the definition of a defined network plan and preferred provider plan.

The proposed rule also reflects numerous modifications arising from a cooperative effort of the Commissioner and representatives from the insurance industry. Since November 2004, four public working meetings have been held to discuss each section of the proposed rule. Each public meeting was attended by the Commissioner and his staff and representatives from the Wisconsin Association of Life and Health Insurers (WALHI), Council for Affordable Healthcare and Wisconsin Association of Provider Networks (WAPN) as well as representatives from no less than seven (7) domestic and non-domestic health insurers. Additional work groups comprised of representatives from industry and the Office met two additional times to work on the ancillary provider language and criteria for preferred provider plans. Participants at the open meetings were invited to comment and make recommendations or specific modifications to the proposed rule. Candid discussion provided both the Commissioner and the industry opportunity to voice support or concerns over each section of the rule. The public working meetings also gave both industry and the Commissioner the opportunity to share its respective views of the marketplace. Discussion often focused on how proposed and revised language affects the industry and its ability to function in the marketplace with the guiding statutory requirements and consumer concerns as reflected in complaints received by the OCI to maintain the proper balance in the proposed regulations. At each meeting revisions that had previously been discussed were reviewed, comment invited with extensive dialogue from both industry and OCI. At the end of the last working public meeting held May 9, 2005, the Commissioner invited written comment on the entire proposed rule. The comment period was intended to provide industry with time to reflect on the proposed rule and offer specific thoughtful revisions or recommendations and then permit the Commissioner time to review the suggested revisions and recommendations prior to issuing the Notice of Hearing for the rule. The culmination of those meetings, including written comments received throughout the last year, is reflected in this proposed rule.

The proposed rule defines preferred provider plans starting with the definition at s. 609.01, Wis. Stats., and clarifies and interprets the statutory requirements. Insurers offering a preferred provider plan cannot require a referral to obtain coverage for care from either a participating or nonparticipating provider. Among other requirements for insurers offering a preferred provider plan, if the insurer uses utilization management, including preauthorization or similar methods, for denying access to or coverage of the services of nonparticipating providers without just cause and with such frequency as to indicate a general business practice, such methods shall result in the insurer's preferred provider plan being treated by the Commissioner as a defined network plan and subject to all requirements of a defined network plan. The Commissioner recognizes that the utilization management and preauthorization as appropriate tools for controlling costs of the insurer and may protect enrollees from incurring additional costs for care. Therefore the proposed rule does not prohibit or limit the proper use of utilization management or preauthorization. OCI will, however, track insurers' use of these tools through complaints and market conduct examination to determine if the insurer has developed a pattern, without just cause, for denying coverage. If such a pattern is uncovered then the insurer would be subject to regulation as a defined network plan.

The proposed rule reflects the amendments within Ch. 609, Stats., by delineating unique reporting and other regulatory requirements between insurers that offer preferred provider plans versus other types of plans including defined network plans, health maintenance and limited service health organizations. Significant provisions that demonstrate the unique regulatory treatment between defined network and preferred provider plans include: defined network plans are required to have quality assurance plans containing standards relating to access to care and continuity and quality of care while preferred provider plans are required to conduct remedial action plans and to develop procedures for remedial action to address quality problems; defined network plans must notify affected enrollees upon the termination of the provider from the plan and preferred providers may contract with another entity or providers to notify the enrollees of the termination, although the preferred provider does remain ultimately responsible for ensuring notifications are sent; defined network plans must report data similar to HEDIS for consumer information and preferred provider plans do not; both defined network plans and preferred provider plans are required to have sufficient number and type of providers within the network to adequately deliver all covered services, however, defined network plans must comply with all access standards while preferred provider plans need to have at least one participating primary care provider and one participating provider that has an expertise in obstetrics and gynecology that is accepting patients but the preferred provider plan need not offer a choice of participating providers.

In order for insurers offering a preferred provider plan to be regulated under the less rigorous regulatory requirements, the insurer must comply with the proposed regulatory requirements. Insurers offering a preferred provider plan must provide the same covered benefits without requiring the enrollee to obtain a referral. The Commissioner recognizes that certain covered services may appropriately be best provided through contracted providers, for example the use of "Centers of Excellence" for transplants or cancer treatment. Further the mandated benefit for immunizations requires the insurer to offer as a covered benefit immunizations but the insurer need only cover the benefit when the immunization is given by a participating provider. Finally, some insurers offer services beyond the mandated limits as covered benefits with a greater differential in coverage and may limit the expanded benefits to services received from participating providers. Therefore, the proposed rule creates a narrow exception to permit specific,

limited services to be covered by participating providers with a greater differential in coverage than when the services are provided by nonparticipating providers including the possibility of coverage only when the services are performed by a participating provider (i.e. immunizations or annual physicals).

As recognized by both the industry and by the Commissioner, deductibles, co-payments and coinsurance are appropriate tools to steer enrollees towards participating providers. Although an appropriate tool, the differences between the deductible, co-payments and coinsurance that an enrollee is required to pay when services are performed by a participating provider as compared to nonparticipating providers should only be enough to create the incentive to utilize preferred providers. The Commissioner over the past year has received and reviewed numerous comments on where the line should be drawn to create the proper balance between the insurers desire to steer enrollees towards participating providers yet not so great that as a result enrollees are exposed to potentially significant financial penalties. Therefore, the proposed rule requires the insurers offering a preferred provider plan that desire to be subject only to the lesser regulatory requirements of preferred provider plans to comply with the following: coverage of the same benefits, unless specifically excepted, with the insurer paying not less than 60% coinsurance and the enrollee paying not more than 40% coinsurance for services performed by a nonparticipating provider. As an alternate, the insurer may pay not less than 50% coinsurance and the enrollee pay not more than 50% coinsurance for the services performed by a nonparticipating provider when the insurer provides the enrollee with a disclosure of limited coverage. Failure of the insurer to offer 60% coinsurance coverage without a disclosure notice or 50% coinsurance coverage with the disclosure notice will result in the insurer being treated as a defined network plan and not eligible for the lesser regulatory standards.

Additionally, the insurer offering a preferred provider plan that applies a coinsurance percentage when services are performed by nonparticipating providers at a different percentage than the coinsurance percentage that is applied when the services are performed by participating providers shall have the difference be no greater than 30%. If the percent difference is greater than 30% the insurer is required to provide the enrollee with a disclosure notice. If an insurer offering a preferred provider plan applies a deductible that is different for participating providers than for nonparticipating providers, the deductible for the same services when performed by a nonparticipating provider must be no more than 2 times greater or no more than $2000 more than the deductible that is applied when performed by a participating provider. If the deductible is more than 2 times greater or is more than $2000 than the deductible that is applied when performed by participating providers, the insurer is required to provide the enrollee with a disclosure notice. If the insurer offering a preferred provider plan applies a co-payment that is different for participating providers than for nonparticipating providers, the co-payment for the same services when performed by a nonparticipating provider must be no more than 3 times greater or no more than $100 for services of a health care provider or no more than $300 for services of a health care facility. If the co-payment is greater than 3 time or more than $100 for health care provider services or more than $300 for health care facilities, the insurer is required to provide the enrollee with a disclosure notice. The disclosure notice that is required to be given is contained within the rule and is similar to the notice provided in the state of Illinois.

An insurer offering a preferred provider plan must apply material exclusions equally regardless if the services are performed by either participating or nonparticipating providers and offer or use no other incentives than the financial incentives of out-of-

pocket limits and maximum limits and cost sharing arrangement including coinsurance, co-payment and deductibles as described above, to encourage its enrollees to use participating providers. The exception to this requirement is for the steering of enrollees to Centers of Excellence for transplants and specified disease treatment services and immunizations pursuant to s. 632.895 (14), Stats., or other preventive health care services when the insurer complies with disclosure requirements at the time the product is marketed, purchased and within the policy form in a prominent location.

Insurers offering a preferred provider plan shall include within the participating provider contracts a provision requiring the participating provider that schedules an elective procedure or other scheduled non-emergency care to fully disclose to the enrollee at the time of scheduling the name of each provider that will or may participate in the delivery of care and whether each provider is a participating or nonparticipating provider. The requirement is for participating providers that are located within Wisconsin or located in the border counties of contiguous states and provide services to Wisconsin enrollees. The insurer shall include a disclosure, in a form consistent with the language contained in Appendix D, which informs enrollees of potential financial implications of using nonparticipating providers and to encourage the enrollee to contact the insurer for assistance in locating an appropriate participating provider. The intent of this requirement is to address the frequent complaint from Wisconsin consumers alleging that although the enrollee sought care from a participating surgeon at a participating hospital, the ancillary providers including anesthesiology or other specialist was nonparticipating and as a result the enrollee incurred large, unexpected medical bills. It is expected that with additional information in advance of the needed service, enrollees will be able to work with insurers and providers to make the best informed medical and financial decisions.

Insurers offering a preferred provider plan are not required to have a quality assurance program and are instead subject to remedial action plans as mentioned earlier. The remedial action plan requires the insurer offering a preferred provider plan to develop procedures for taking effective and timely remedial actions to address issues arising from access to and continuity of care. The proposed rule requires the remedial action plan to contain at least all of the following: designation of a senior-level staff person responsible for oversight of the plan, a written plan for the oversight of any function that is delegated to other contracted entities, a procedure for periodic review of the insurer's performance or the performance of a contracted entity, periodic and regular review of grievances, complaints and OCI complaints, a written plan for maintaining the confidentiality of protected information, documentation of timely correction of access to and continuity of care issues identified in the plan to include the date the insurer was aware of the issue, the type of issue, the person responsible for the development and management of the plan, the remedial action plan utilized in each situation, the outcome of the action plan, and the established time frame for reevaluation of the issue to ensure resolution and compliance with the remedial action plan

Emergency medical care treatment coverage was identified by the Commissioner as another specific type of service for which the Office frequently receives complaints from Wisconsin consumers. This form of regulation is found in the surrounding states and is most similar to the regulation in Iowa. To further clarify the prudent person mandate for coverage of emergency medical care, the proposed rule contains requirements for both insurers offering a defined network plan and preferred provider plan that provide emergency medical care treatment as a covered benefit. These insurers shall provide that treatment as though the provider was a participating provider when the enrollee

cannot reasonably reach a preferred provider or is admitted for inpatient care even if the care is provided by a nonparticipating provider. The plans must reimburse the provider at the nonparticipating provider rate and apply any deductibles, co-payments, coinsurance or other costsharing provisions, if applicable, at the participating provider rate.

Insurers offering defined network plans and preferred provider plans are both required to annually certify compliance with applicable access standards. Insurers offering defined network plans and preferred providers plans must both provide covered benefits by plan providers with reasonable promptness with respect to geographic location, hours of operation waiting times for appointments in provider offices and after hours care reflecting the usual practice in the local area with geographic availability reflecting the usual medical travel times within the community. This requirement is not new and does not require insurers to mandate to participating providers the provider's hours of operation. Rather when the insurer is required to reply to the Office, the insurer must demonstrate that the hours of operation, waiting time for appointments and after hours care of the participating providers is reasonable based upon the geographic location and usual medical travel times within that community.

The Commissioner finds that the circumstances of insurers offering a group or blanket health insurance policy require that the insurer offering the policy otherwise exempt from Chs. 600 to 646, Stats., under s. 600.01 (1) (b) 3., Stats., in order to provide adequate protection to Wisconsin enrollees and the public those insurers shall comply with s. Ins 9.32 (2) and s. 609.22 (2), Stats., when it covers 100 or more residents of this state under a policy that is otherwise exempt under s. 600.01 (1) (b) 3., Stats.

Finally, the proposed rule includes several new definitions of terms that were requested by the industry to assist in clarifying relationships between insurers and providers and to clarify what entities are subject to specific requirements.

The proposed rule would be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats. This proposed rule includes a significantly delayed applicability date to give insurers ample time to comply with the various provisions including sufficient time to submit to the OCI forms for approval prior to use.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

There is no existing or proposed federal regulation that is intended to address the issues presented within the proposed rule. There is federal regulation for issuers of Medicare Advantage, a means of delivering Medicare Part A and B benefits through preferred provider organizations, formally known as Medicare + Choice. States are preempted from regulating issuers of Medicare Advantage, however the Centers for Medicare & Medicaid did provide regulations that included access requirements which are similar to the requirements incorporated in the OCI proposed rule.

7. Comparison of similar rules in adjacent states as found by OCI:

Iowa: Iowa statute §514C.16, requires a carrier which provides coverage for emergency services to be responsible for charges for emergency services furnished outside any contractual provider network or preferred provider network for covered individuals. Iowa Administrative Code s. 191-27.4 (1)(a), requires a health benefit plan which provides for incentives for covered persons to use the health care services of a preferred provider to contain a provision that if a covered

person receives emergency services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, emergency services rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider, subject to any restrictions which may govern payment by a preferred provider for emergency services. Iowa statute §514B and Administrative Code 191-40.21, require HMOs to reimburse a provider of emergency services after a review of the care and may not deny reimbursement solely on the grounds that the services were provided by non-contracted providers.

Iowa statute §514F.3 requires the commissioner of insurance to adopt rules for preferred provider contracts and organizations and to adopt rules related to preferred provider arrangements. Iowa statute §514K.1 requires HMOs, organized delivery systems or an insurer using a preferred provider arrangement to provide to its enrollees written information that at a minimum must include the following; a description of the plan's benefits and exclusions, enrollee cost-sharing requirements, list of participating providers, disclosure of drug formularies, explanation for accessing emergency care services, policy for addressing investigational or experimental treatments, methodologies used to compensate providers, performance measures as determined by the commissioner and information on how to access internal and external grievance procedures. In addition the Iowa department must annually publish a consumer guide providing a comparison by plan on performance measures, network composition, and other key information to enable consumers to better understand plan differences.

Iowa Administrative Code 191-27.3 (1), requires preferred provider arrangements to establish the amount and manner of payment to a preferred provider, the mechanisms designed to minimize cost of the health benefits plan and ensure reasonable access to covered services under the preferred provider arrangement. Iowa Administrative Code 191-27.4 (1) (b), requires preferred provider plans to contain a provision that clearly identifies the differentials in benefit levels for health care services of preferred providers and non-preferred providers. Iowa Administrative Code 191-27.4 (2), requires that if a health benefit plan provides difference in benefit levels payable to preferred providers compared to other providers, such difference shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

Illinois: Illinois statutory code 215 ILCS 5/370o, requires any preferred provider contract to provide the enrollee emergency care coverage regardless of whether the emergency care is provided by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a plan provider. Section 215 ILCS 5/370i, sec. (a) prohibits policies from containing provisions that would unreasonably restrict the access and availability of health care services for the enrollee. Section 215 ILCS 134/40, sec. 40 (d) requires a health care plan to pay for services of a specialist with the enrollee only responsible for the services as though the services were provided by an in-network provider when the plan does not have the specialist that the enrollee needs for the care of an on-going specific condition. The primary care physician arranges for the enrollee to see a specialist that is within

a reasonable distance and travel time and the primary provider notifies the plan of the referral.

The information required to be provided to consumers is contained in s. 215 ILCS 134/15, that requires annual reporting of participating health care providers in the plan's service area and in addition to basic terms of the plan, includes disclosure of out-of-area coverage, if any, financial responsibility of enrollees including co-payments, deductibles, premium and any other out-of-pocket expenses, continuity of care, appeal rights and mandated benefits. Illinois Administrative Code s. 5420.40, requires disclosure so that a person can compare the attributes of various health care plans based upon a description of coverage. This disclosure includes that 2 appendices are completed that detail specific co-payments, coinsurance, deductibles, and other cost-sharing provisions for services that must be included with the policy for consumer information.

In addition to the worksheets that provide consumers with detailed information, Illinois statutory code s. 215ILCS 5/356z.2, also requires an insurer that issues or renews a individual or group accident and health policy and arranges, contracts with or administers contracts with providers whereby the beneficiary are provided an incentive to use the services of such provider must include the following disclosure of limited benefits in its contracts and evidence of coverage:

> WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical are where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card. (Emphasis in original.)

Illinois statute s. 215 ILCS 134/80 requires that health care plans have procedures for quality assessment program including in s. (3) and (4) that require plans have a procedure for remedial action to correct quality problems that have been verified in accordance with the written plan's methodology and criteria, including written procedures for taking appropriate corrective action and follow-up measures implemented to evaluate the effectiveness of the action plan.

Illinois Administrative Code s. 5420.50 requires that all provider agreements contain provisions providing for advance notice from providers when terminating from the plan and requirements that the plan notify affected enrollees on a timely basis. The notice provided to the enrollee must contain information on how enrollees are to select a new health care provider.

Minnesota: Minnesota statute s. 62A.049, prohibits an accident and sickness policy from requiring prior authorization in cases of emergency confinement or emergency treatment. The enrollee or authorized representative must notify the insurer as soon as reasonably possible. Section 62Q.55 requires managed care organizations including preferred provider organization, to provide enrollees with available and accessible emergency services. Services shall be covered whether provided by participating or nonparticipating providers and whether provided within or outside the health plan's service area. Section 62D.20 and s. 4685.0700, Minnesota Administrative Code, require HMOs to provide out-of-area services including for emergency care.

Minnesota statute s. 62Q.49 (subd. 2) (a), requires all health plans to clearly specify how the cost of health care used to calculate any co-payments, coinsurance or lifetime benefits will be affected by the contracting in which health care providers agree to accept discounted charges. Further any marketing or summary materials must be disclosed prominently and clearly explain the provisions relating to co-payments, coinsurance or maximum lifetime benefits.

Minnesota statute s. 62Q.58, requires that if an enrollee receives services from a nonparticipating specialist because a participating specialist is not available, the services must be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received from a participating specialist.

Minnesota statute s. 62Q.746, permits the department to request and the health plan to provide the following information including how the plan determines who are eligible to participating in the network, the number of full-time equivalent physicians, by specialty, non-physician providers and allied health providers used to provide services and summary data that is broken down by type of provider reflecting actual utilization of network and non-network practitioners and allied professionals by enrollees of the plan.

Michigan: Michigan statute s. 500.3406k, requires an expense-incurred hospital, medical or surgical policy that provides coverage for emergency health services, including an HMO plan, to provide coverage for medically necessary services provided to an enrollee for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, that the absence of immediate care could reasonably be expected to result in serious jeopardy to health without prior authorization.

Insurers that contract with providers are governed by the Prudent Purchaser Act of 1984 including preferred provider organization (MCL 550.50 et seq.). The organization that contracts with providers shall annually report to the commissioner basic utilization of the providers (MCL 550.56). Under MCL 550.53, organizations that contract with providers to control costs and utilization may limit the number of providers to the number necessary to assure reasonable levels of access to health care services, located within reasonable distance.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

The rule as drafted by OCI is intended to ensure enrollee access to health care services, ensure continuity of health care and ensure that enrollees fully understand the products offered including deductibles, co-payment and other cost-sharing measures that when combined with premium payments will permit the enrollee to make better product selection and provider choices. The proposed rule achieves these goals while recognizing the differences between preferred provider plans and defined network plans. In addition to the statutory amendments necessitating the rule, the OCI identified several key consumer and regulatory issues through a review of complaints filed with the agency involving insurers offering preferred provider plans (PPOs) that the proposed rule addresses through required disclosures to enrollees, disclosure to the OCI, coverage of emergency services and adequate access to participating providers.

The complaint review involved complaints filed for the period January 1, 2003 through May 31, 2004. The OCI reviewed only complaints identified in the agency data system as group health coverage. The OCI identified 936 PPO complaints. These complaints involved claim administration (83%), marketing (2%), underwriting (9%), policyholder service (5%) and "other" complaints (1%).

The OCI found that 33 complaints involved ancillary providers. These complaints involve PPO plans that have participating provider contracts with hospitals but do not have contracts with the anesthesiologists, radiologists, pathologists and emergency medicine physicians associated with in-network hospitals. Enrollees either were not aware that the ancillary providers were non-participating providers or did not have an option but to use the non-participating providers due to location or medical necessity. The result to these enrollees was significant out-of-pocket expenses as some PPOs have 30% or more differential between participating and non-participating providers and may also have higher co-payments or other cost-sharing provisions when services are performed by non-participating providers.

During this same period of time, the OCI identified 15 complaints involving emergency services that were subject to non-participating deductibles and co-payments. Although some insurers waive the deductible and co-payments billed by nonparticipating providers for rendering emergency care services, many insurers leave enrollees financially responsible for significant, unexpected, medical expenses.

The OCI also identified 19 complaints that involved changes in the provider networks, 2 complaints involving limits in the available participating network, 18 involving the enrollee's lack of understanding of PPO plan requirements with 71 complaints grouped under the heading of "other" which includes UCR determinations, and pre-certification or pre-authorization issues.

In addition to the complaint review, the OCI in a cooperative effort of the Commissioner met with representatives from the insurance industry. Since November 2004, four public working meetings have been held to discuss each section of the proposed rule. Each public meeting was attended by the Commissioner and his staff and representatives from the Wisconsin Association of Life and Health Insurer, Council for Affordable Healthcare and Wisconsin Association of Provider Networks as well as representatives from no less than seven (7) domestic and non-domestic health insurers. Additional work groups comprised of representatives from industry and the Office met two additional times to work on the ancillary provider language and criteria for preferred provider plans.

Participants in the open meetings were invited to comment and make recommendations or specific modifications to the proposed rule. Candid discussion provided both Commissioner and the industry opportunity to voice support or concerns over each section of the rule. The public working meetings also gave both industry and the Commissioner the opportunity to share its respective views of the marketplace. Discussion often focused on how proposed and revised language affects the industry and its ability to function in the marketplace with the guiding statutory requirements and consumer concerns as reflected in complaints received by the OCI to maintain the proper balance in the proposed regulations. At each meeting revisions that had previously been discussed were reviewed, comment invited with extensive dialogue from both industry and OCI. At the end of the last working public meeting held May 9, 2005, the Commissioner invited written comment on the entire proposed rule. The comment period was intended to provide industry with time to reflect on the proposed rule and offer specific thoughtful revisions or recommendations and then permit the Commissioner time to review the suggested revisions and recommendations prior to issuing the Notice of Hearing for the rule. The culmination of those meeting, including written comments received throughout the last year, is reflected in this proposed rule.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

This rule may have an effect on only one (1) regulated small business as defined in s. 227.114 (1), Wis. Stats., that is an LSHO and that has been authorized by the commissioner to only write 10% of its premium as a preferred provider plan. OCI maintains a database of all licensed insurers in Wisconsin. Included with the information required to be submitted to OCI, the database includes information submitted by the companies related to premium revenue and employment. In an examination of this database, OCI identified only one insurer with annual premium volume of less than $5 million that would be affected by this proposed rule.

This one insurer would incur a one-time expense associated with filing new policy forms, modifying provider contracts and implementing remedial action plan procedures related to quality problems. It is possible that the one insurer might need to minimally modify its computer system to the extent necessary to incorporate emergency medical care rendered by nonparticipating providers. These one-time expenses are not considered to be of significant cost and therefore will not have a significant economic impact on the one insurer.

Further, the proposed rule has a delayed applicability date for new policies to January 1, 2007 and renewing policies to January 1, 2008. The significantly delayed applicability will allow the insurer to spread any cost that it may incur over time thus reducing any effect the rule might have on the one insurer. The delay will also give the insurer ample time to make necessary modifications to forms or contracts also minimizing any affect of the rule on the small business insurer.

10. If these changes may have a significant fiscal effect on the private sector, the anticipated costs that will be incurred by private sector in complying with the rule:

This rule is not expected to have a significant fiscal effect on the private sector regulated by OCI. The majority of insurers offering a defined network plan, including health maintenance organization and most preferred provider plans currently offer insurance coverage that complies with the minimum standards proposed in the amendments to ch. Ins 9, Wis. Adm. Code. The proposed rule does not prohibit or require insurers offering

a preferred provider plan to redesign any existing plan. Insurers may continue selling and servicing policies that contain coinsurance, co-payments, deductibles or other cost-sharing methods, however those plans may be required to include disclosure notices that will need to be filed with the Office prior to use. In addition insurers offering a defined network or a preferred provider plan will be required to submit to the OCI emergency medical care coverage language that is compliant with the regulation.

Insurers offering a preferred provider plan will likely need to incur a one-time expense to modify existing contracts with participating providers through an addendum to comply with advance notice to enrollees regarding providers' plan status when elective procedures are scheduled. Additionally, the insurers may need to file updated forms and implement remedial action plans to address quality problems. It is possible that insurers might need to minimally modify existing computer systems for payment of emergency medical care services provided by nonparticipating providers.

Insurers may find a cost saving resulting from the rule through the receipt of fewer complaints from enrollees, employers and providers, and use fewer resources investigating and responding to complaints and grievances, and in preparing and documenting files for external review. Further, with significantly delayed applicability dates, insurers will have ample time to make necessary modifications including sufficient time to file any necessary form filings thereby reducing any possible effect of the proposed rule.

11. A description of the Effect on Small Business:

This rule may effect one small business regulated by the Office but should not have a significant economic impact. OCI identified one insurer that is an LSHO authorized to write no more than 10% of its premium from preferred provider business that had annual premium volume of less than $5 million, however the effect would not have a significant economic impact on that insurer for the reasons stated above.

The insurer that may be affected by the proposed rule will incur a one-time expense related to the filing of compliant policy forms, modifying provider contracts and implementing a remedial action plan procedure related to quality problems. The proposed rule also includes a significantly delayed applicability date allowing the one insurer ample time for necessary modifications and to spread any associated costs over time thus limiting any effect the rule might have.

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the WEB sites at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: Inger.Williams@OCI.State.WI.US
Address: 125 South Webster St – 2nd Floor Madison WI 53702
Mail: PO Box 7873, Madison WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule INS 9
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule INS 9
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53702

WEB Site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. INS 3.67 (1) (a) and (e) are renumbered Ins 3.67 (1) (am) and (a), and Ins 3.67 (1) (a), as renumbered, is amended to read:

3.67 (1) (e~~a~~a) "~~Managed care~~Defined network plan" has the meaning provided under s. 609.01 (1b), Stats.

SECTION 2. INS 3.67 (1) (c) is amended to read:

3.67 (1) (c) "Grievance" means any dissatisfaction with the ~~administration,~~provision of services or claims practices ~~or provision of services by a managed care~~ of an insurer offering a defined network plan, limited service health organization or preferred provider plan or administration of a defined network plan, limited service health organization or preferred provider plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an enrollee.

SECTION 3. INS 3.67 (4) (intro.) is amended to read:

3.67 (4) (intro.) APPEAL PROCEDURE. The procedure for ~~managed care~~defined network plan enrollees to appeal a decision under ~~sub.~~subs. (2) and (3) is delineated under s. Ins 18.03.

For other health care plans, the appeal procedure established under this section shall include all of the following:

SECTION 4. Chapter INS 9 (title) is amended to read:

CHAPTER INS 9

~~MANAGED CARE~~DEFINED NETWORK PLANS

SECTION 5. INS 9.01 (intro.) and (3) are amended to read:

9.01 (intro). In ~~addition to the following definitions in s. 609.01, Stats., in~~ this chapter, and for the purposes of applying ch. 609, Stats.:

9.01 (3) "Complaint" means any expression of dissatisfaction ~~about an~~ expressed to an insurer ~~or its contracted providers expressed~~ by an enrollee, or an enrollee's authorized representative, ~~to the insurer~~ about the insurer or its participating providers.

SECTION 6. INS 9.01 (12) is renumbered to s. Ins 9.01 (3m) and amended to read:

9.01 (~~12~~3m). "~~Managed care~~Defined network plan" has the meaning provided under s. 609.01 (~~3c~~1b), Stats., and includes ~~Medicare+Choice plan as defined in s. Ins 3.39 (3)(cm),~~ Medicare ~~Select policy~~ select policies as defined in s. Ins 3.39 (30) (b) 4., and health benefit plans that ~~either directly or indirectly~~ contract for use of participating providers.

SECTION 7. INS 9.01 (5) is amended to read:

9.01 (5) "Grievance" means any dissatisfaction with the ~~administration,~~ provision of services or claims practices ~~or provision of services by a managed care~~ of an insurer offering a defined network or limited scope plan, ~~limited service health organization or preferred provider plan~~ or administration of a defined network or limited scope plan, that is expressed in writing to the insurer by, or on behalf of, an enrollee.

SECTION 8. INS 9.01 (9m), (10m) and (14m) are created to read:

9.01 (9m) "Intermediate entity" means a provider network, a provider association, a provider leasing arrangement or other similar entity that contracts with providers for the rendering of health care services, items or supplies to enrollees of a defined network plan, preferred provider plan or limited scope plan and also contracts with the insurer offering a defined network plan, preferred provider plan or limited scope plan.

9.01 (10m) "Limited scope plan" means an insurer offering a health care plan that provides limited-scope dental or vision benefits under a separate policy, certificate or contract of insurance in accordance with s. 632.745 (11) (b) 9., Stats.

9.01 (14m) "Participating" has the meaning provided under s. 609.01 (3m), Stats., and includes a provider as being under contract with the insurer when the provider is under contract with an intermediate entity.

SECTION 9. INS 9.01 (13), (17) (intro.), (17) (a) and (c) are amended to read:

9.01 (13) "OCI complaint" means any written complaint received by the office of the commissioner of insurance by, or on behalf of, an enrollee of ~~a managed care plan~~ an insurer offering a defined network or limited scope plan.

9.01 (17) "Silent provider network" means one or more participating providers that provide services covered under a ~~managed care~~defined network plan where all of the following apply:

(a) The insurer does not include any incentives or penalties in the ~~managed care~~defined network plan related to utilization or failure to utilize the provider.

(c) The insurer, in any arrangement described under par. (b), requires that the reduction in fees will be applied with respect to cost sharing portions of expenses incurred under the

~~managed care~~defined network plan to the extent the provider submits the claim directly to the insurer.

SECTION 10. INS 9.07 (1) is amended to read:

9.07 Copies of provider agreements. **(1)** Notwithstanding any claim of trade secret or proprietary information, all ~~managed care plan and limited service health organization~~ insurers offering a defined network or limited scope plan shall, upon request~~,~~ from the commissioner, make available to the commissioner all executed copies of any provider agreements between the insurer and ~~subcontracts with individual practice associations~~ intermediate entities or individual providers. ~~Managed care plans, provider networks or independent practice associations~~ Any party to a provider agreement may assert that a portion of the contracts contain trade secrets, and the commissioner may withhold that portion ~~from the insurer~~ to the extent it may be withheld under s. Ins 6.13.

SECTION 11. Subchapter III (title) INS 9 is amended to read:

SUBCHAPTER III: MARKET CONDUCT STANDARDS FOR ~~MANAGED CARE~~DEFINED NETWORK PLANS.

SECTION 12. INS 9.30 is repealed.

SECTION 13: Ins 9.31 and 9.32 are renumbered Ins 9.20 and 9.21 and Ins 9.20 (intro.) and 9.21 (1), (2) (intro.), (a) and (d), as renumbered, are amended to read:

~~9.31~~9.20 Scope. This subchapter applies to all insurers ~~providing managed care plans, or limited service heath organization plans~~ offering a defined network or limited scope plan in this state. The insurer shall ensure that the requirements of this subchapter are met by all ~~managed care plans, preferred provider plans or limited service health organization plans~~ defined network or limited scope plans issued by the insurer. The commissioner may approve an exemption to this subchapter for an insurer to market a ~~managed care plan, preferred~~

~~provider plan or limited service health organization plan~~ defined network or limited scope plan if the insurer files the plan ~~is filed~~ with the commissioner and the commissioner determines that all of the following conditions are met:

9.~~32~~21 Limited exemptions. (1) SILENT DISCOUNT. An insurer, with respect to a ~~managed care~~defined network plan:

(a) Is exempt from meeting the requirements under ss. 609.22, 609.24, 609.32, 609.34, 609.36, and 609.83 Stats., and ss. Ins ~~9.33, 9.34~~ 9.31, 9.32 (1), 9.35, 9.37, 9.38, 9.39, 9.40 (1) to (7), 9.42 (1) to (7), if the only owned, employed or participating provider providing services covered under the plan is a silent provider network.

(b) Is exempt from meeting the requirements under ss. 609.22, 609.24, 609.32, 609.34, and 609.36, Stats., and ss. Ins ~~9.34~~9.32 (1), 9.35, 9.37, 9.38, 9.39, 9.40 (1) to (7), and 9.42 (1) to (7), solely with respect to services provided by the silent provider network, if the plan also covers services by providers that the insurer owns or employs, or another participating provider. An insurer is not exempt from those provisions with respect to a provider that is not a silent provider network.

(2) DE MINIMUS LIMITED EXCEPTION. Insurers ~~writing managed care plans~~ offering a defined network plan are exempt from meeting the requirements under ss. 609.22 (1) to (4) and (8), 609.32 and 609.34, Stats., and ss. Ins ~~9.34 (2) (a) and (b)~~9.32 (1), 9.40 (1) to (7), and 9.42 (6) and (7), with respect to a ~~managed care~~defined network plan, if the insurer meets all of the following requirements.

(a) The ~~managed care~~ insurer offering a defined network plan provides comprehensive benefits to enrollees of at least 80% coverage for in-plan providers.

(d) The insurer makes no representation that the ~~managed care~~defined network plan is a preferred provider plan or that the defined network plan directs or is responsible for the quality

of health care services. Nothing in this paragraph prevents an insurer from describing the availability or limits on availability of participating providers or the extent or limits of coverage under the ~~managed care~~defined network plan if participating or nonparticipating providers are utilized by an enrollee.

SECTION 14. INS 9.25, 9.26, 9.27, 9.30, 9.32 and 9.33 are created to read:

9.25 Preferred provider plan same service provisions. For purposes of s. 609.35, Stats., an insurer offering a preferred provider plan covers the same services when performed by a nonparticipating provider that it covers when those services are performed by a participating provider only if the insurer complies with all of the following:

(1) The insurer offering a preferred provider plan provides coverage that complies with either of the following:

(a) Provides coverage for services performed by nonparticipating providers with the insurer paying at a coinsurance rate of not less than 60% and the enrollee paying at a coinsurance rate of not more than 40%.

(b) Provides coverage for services performed by nonparticipating providers with the insurer paying at a coinsurance rate not less than 50% and the enrollee paying at a coinsurance rate of not more than 50% and the insurer provides the enrollee with the disclosure notice that is compliant with sub. (5).

(2) The insurer offering a preferred provider plan equally applies material exclusions regardless if the services are performed by either participating or nonparticipating providers. The insurer may exceed the coinsurance differential in s. Ins 9.27 (1), or the deductible differential in s. Ins 9.27 (2), or the co-payment differential in s. Ins 9.27 (3) to the extent the insurer reasonably determines the cost sharing is necessary to encourage enrollees to use participating providers or centers of excellence for transplant or other unique disease treatment

services or preventive health care services limited to immunizations pursuant to s. 632.895 (14), Stats., and the services as covered benefits greater than the minimum required for specific mandated benefits under ss. 632.895 and 632.89, Stats., when the insurer at the time of solicitation and within the policy, does either or both, as applicable, of the following:

(a) Provides a disclosure to enrollees that identify the centers of excellence and the specific covered benefits that are covered at a different rate if provided by a health care provider that is recognized and identified as a center of excellence.

(b) Clearly and prominently discloses that either immunizations or expanded benefits above mandated minimum coverage, or both, are covered when performed by participating providers or with greater disparity than permitted in s. Ins 9.27 (1) through (3).

(3) The insurer offering a preferred provider plan provides coverage of services without use of any financial incentives other than maximum limits, out-of-pocket limits and those incentives described in this section and s. Ins 9.27 to encourage the use of participating providers.

(4) The insurer offering a preferred provider plan may use utilization management, including preauthorization or similar methods, for denying access to or coverage of services of nonparticipating providers with just cause and without such frequency as to indicate a general business practice. Using utilization management, including preauthorization or similar methods, for denying access to or coverage of services of nonparticipating providers without just cause and with such frequency as to indicate a general business practice, as determined by the commissioner, results in the plan being treated by the commissioner as a defined network plan and subject to all requirements of a defined network plan.

(5) An insurer required to provide a disclosure notice under sub. (1) shall provide the disclosure notice to the applicant at the time of solicitation, and shall include in a prominent

location within the certificate of coverage issued under a group policy and in a prominent location in an individual policy, the following form and in not less than 11-point bold font:

"NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered service, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical are where the services are performed), or other method as defined by the policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND CO-PAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Nonparticipating providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than co-payment, coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling [the toll free telephone] number on your identification card [or visiting [the company's] website].

(6) The insurer files a report with the commissioner certifying compliance with this section on a form prescribed by the commissioner and signed by an officer of the company.

(7) The insurer does not require a referral to obtain coverage for care from either a participating or nonparticipating provider and complies with ss. Ins 9.27 and 9.32 (2).

Ins 9.26 Preferred provider plan subject to defined network plan regulations. An insurer offering 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 the requirements of a defined network plan that is not a preferred provider plan including ss. Ins 9.31, 9.32 (1), 9.35 (1), 9.37 (4), 9.40 (2), (4) and (6), and 18.03(2) (c) 1., and ss. 609.22 (2), (3), (4) and (7), 609.32 (1) and 609.34 (1), Stats.

Ins 9.27 Preferred provider plan requirements. Insurers offering a preferred provider plan shall comply with all the following:

(1) Except as provided in s. Ins 9.25 (2), insurers offering a preferred provider plan that apply a coinsurance percentage when the services are performed by nonparticipating providers at a different percentage than the coinsurance percentage that is applied when the services are performed by participating providers shall offer plans that have either of the following:

(a) The coinsurance differential between participating and nonparticipating providers performing the same services is 30% or less.

(b) The coinsurance differential between participating and nonparticipating provider performing the same services is greater than 30% and the insurer provides the enrollee with a disclosure notice that is compliant with s. Ins 9.25 (5).

(2) Except as provided in s. Ins 9.25 (2), insurers offering a preferred provider plan that apply a deductible when the services are performed by nonparticipating providers in a different amount than the deductible that is applied when the services are performed by participating providers shall offer plans that have either of the following:

(a) The deductible applied to nonparticipating providers is no more than 2 times greater than the deductible applied to participating providers or no more than $2000 higher than the participating provider deductible.

(b) The deductible applied to nonparticipating providers is more than 2 times greater than the deductible applied to participating providers or is more than $2000 higher than the

participating provider deductible and the insurer provides the enrollee with a disclosure notice that is compliant with s. Ins 9.25 (5).

(3) Except as provided in s. Ins 9.25 (2), insurers offering a preferred provider plan that apply a co-payment when the services are performed by nonparticipating providers in a different amount than the co-payment that is applied when the services are performed by participating providers shall offer plans that have either of the following:

(a) The co-payment applied to nonparticipating providers is no more than 3 times greater than the co-payment applied to participating providers or no more than $100 for services of a health care provider or no more than $300 for services of a health care facility.

(b) The co-payment applied to nonparticipating providers is more than 3 times greater than the co-payment applied to participating providers or is more than $100 for services of a health care provider or is more than $300 for services of a health care facility and the insurer provides the enrollee with a disclosure notice that is compliant with s. Ins 9.25 (5).

9.30 Group and blanket health insurers compliance. The commissioner finds that the circumstances of offering a group or blanket health insurance policy require that the insurer offering the policy otherwise exempt from chs. 600 to 646, Stats., under s. 600.01 (1) (b) 3., Stats., comply with s. Ins 9.32 (2) and s. 609.22 (2), Stats., in order to provide adequate protection to Wisconsin enrollees and the public. An insurer that covers 100 or more residents of this state under a policy otherwise exempt under s. 600.01 (1) (b) 3., Stats., shall comply with s. Ins 9.32 (2) and s. 609.22 (2), Stats.

9.31 Annual certification of access standards. (1) An insurer offering a defined network plan that is not a preferred provider plan shall file an annual certification with the commissioner no later than August 1 of each year certifying compliance with the access standards of s. 609.22, Stats., and s. Ins 9.32 (1) for the preceding year. The certification shall

be submitted on a form prescribed by the commissioner and signed by an officer of the company.

(2) An insurer offering a preferred provider plan shall file an annual certification with the commissioner no later than August 1 of each year certifying compliance with the access standards contained in ss. 609.22 (1), (4m), (5), (6) and (8), Stats., and s. Ins 9.32 (2) for the preceding year, on a form prescribed by the commissioner and signed by an officer of the company. The certification is to be filed within 3 months after the effective date of this section . . . .[revisor to insert date], and thereafter, no later than August 1 of each year.

Note: A copy of the certification of access standards form required under sub. (1), OCI26-110, and sub. (2), OCI26-111, may be obtained at no cost from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI, 53707-7873 or from the OCI website address: http://oci.wi.gov.

9.32 Defined network plan requirements. (1) An insurer offering a defined network plan that is not a preferred provider plan shall do all of the following:

(a) Provide covered benefits by plan providers with reasonable promptness with respect to geographic location, hours of operation, waiting times for appointments in provider offices and after hours care. The hours of operation, waiting times, and availability of after hours care shall reflect the usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community.

(b) Have sufficient number and type of plan providers to adequately deliver all covered services based on the demographics and health status of current and expected enrollees served by the plan.

(c) Provide 24-hour nationwide toll-free telephone access for its enrollees to the plan or to a Wisconsin participating provider for authorization for care which is covered by the plan.

(d) Provide as a covered benefit the emergency services rendered during the treatment of an emergency medical condition, as defined by s. 632.85, Stats., by a nonparticipating provider as though the services was provided by a participating provider, if the insurer provides coverage for emergency medical services and the enrollee cannot reasonably reach a participating provider or, as a result of the emergency, is admitted for inpatient care subject to any restriction which may govern payment to a participating provider for emergency services. The insurer shall pay the nonparticipating provider at the rate the insurer pays a nonparticipating provider after applying any co-payments, coinsurance, deductibles or other cost-sharing provisions that apply to participating providers.

(2) An insurer offering a preferred provider plan shall do all of the following:

(a) Provide covered benefits by participating providers with reasonable promptness with respect to geographic location, hours of operation, waiting times for appointments in provider offices and after hours care. The hours of operation, waiting times, and availability of after hours care shall reflect the usual practice in the local area. Geographic availability shall reflect the usual medical travel times within the community. This does not require an insurer offering a preferred provider plan to offer geographic availability of a choice of participating providers.

(b) Provide sufficient number and type of participating providers to adequately deliver all covered services based on the demographics and to meet the anticipated needs of its enrollees served by the plan including at least one primary care provider and a participating provider with expertise in obstetrics and gynecology accepting new enrollees.

(c) Include in all contracts with participating providers that are located in Wisconsin or located in the border counties of contiguous states and provide services to Wisconsin enrollees, a provision requiring the participating provider that schedules an elective procedure or other scheduled non-emergency care to fully disclose to the enrollee at the time of scheduling the

name of each provider that will or may participate in the delivery of the care and whether each provider is a participating or nonparticipating provider.

(d) Include in its provider directory a prominent notice that complies with Appendix D and is printed in 11-point bold font.

(e) Provide the covered benefits provided by nonparticipating providers involved in the scheduled elective or non-emergency scheduled care at the rate the insurer pays a nonparticipating provider after applying any co-payments, coinsurance, deductibles or other cost-sharing provisions that apply to participating providers when the enrollee receives care from a nonparticipating provider and either of the following occurs:

1. The insurer fails to comply with par. (c). Failure of the insurer includes the failure of its participating provider to comply with the terms of the contract.

2. The insurer fails to comply with par. (d).

(f) Provide as a covered benefit the emergency services rendered during the treatment of an emergency medical condition, as defined by s. 632.85, Stats., by a nonparticipating provider as though the services were provided by a participating provider, if the insurer provides coverage for emergency medical services and the enrollee cannot reasonably reach a participating provider or, as a result of the emergency, is admitted for inpatient care, subject to any restriction that may govern payment to a participating provider for emergency services. The insurer shall pay the nonparticipating provider at the rate the insurer pays a nonparticipating provider after applying any co-payments, coinsurance, deductibles or other cost-sharing provisions that apply to participating providers.

9.33 Enrollee election of nonparticipating provider reimbursement. Nothing in s. Ins 9.32 changes the reimbursement payable or the amounts due, including co-payments, coinsurance, deductibles and other cost-sharing provisions from an enrollee when the enrollee

of a preferred provider plan that is not a defined network plan elects to utilize the services of a nonparticipating provider when a participating provider is available in accordance with s. Ins 9.32 (2) (a) and (b) and the requirements of s. Ins 9.32 (2) (c) and (d), including the information from the participating provider, are provided to the enrollee.

SECTION 15. INS 9.34 is repealed.

SECTION 16. INS 9.35, 9.36 and 9.37 (1) (intro.), (2), (3), and (4) are amended to read:

9.35 Continuity of care. **(1)** In addition to the requirements of s. 609.24, Stats., ~~a managed care~~ an insurer offering a defined network plan shall do ~~either~~one of the following:

(a) Upon termination of a provider from a ~~managed care~~defined network plan, the insurer offering a defined network plan shall appropriately notify all enrollees of the termination, provide information on substitute providers, and at least identify the terminated providers within a separate section of the annual provider directory. In addition, the ~~plan~~insurer shall comply with all of the following as appropriate:

1. If the terminating provider is a primary care provider and the ~~managed care~~ insurer offering a defined network plan requires enrollees to designate a primary care provider, the ~~plan~~insurer shall notify each enrollee who designated the terminating provider of the termination ~~the greater of~~no later than 30 days prior to the termination or 15 days following the ~~insurer's receipt of~~ date the insurer received the provider's termination notice, whichever is later, and shall describe each enrollee's options for receiving continued care from the terminated provider.

2. If the terminating provider is a specialist and the ~~managed care~~insurer offering a defined network plan requires a referral, the ~~plan~~insurer shall notify each enrollee authorized by referral to receive care from the specialist of the termination ~~the greater of~~no later than 30 days prior to the termination or 15 days following the ~~insurer's receipt of~~ date the insurer received the

provider's termination notice, whichever is later, and describe each enrollee's options for receiving continued care from the terminated provider.

3. If the terminating provider is a specialist and the ~~managed care~~insurer offering a defined network plan does not require a referral, the provider's contract with the ~~plan~~insurer shall comply with the requirements of s. 609.24, Stats., and require the provider to post a notification of termination with the plan in the provider's office ~~the greater of~~no later than 30 days prior to the termination or 15 days following the date the ~~insurer's receipt of~~insurer received the provider's termination notice, whichever is later.

(b) 1. Upon termination of a provider from a ~~managed care~~defined network plan, the insurer offering a defined network plan shall notify all affected enrollees of the termination and each enrollee's options for receiving continued care from the terminated provider not later than 30 days prior to the termination, or upon notice by the provider if the ~~plan~~insurer receives less than 30 days notice. ~~A managed care~~ The insurer offering a defined network plan shall provide information on substitute providers to all affected enrollees.

2. If the provider is a primary care provider and the ~~managed care~~insurer offering a defined network plan requires enrollees to designate a primary care provider, the ~~plan~~insurer shall notify all enrollees who designated the terminating provider.

(1m) An insurer offering a preferred provider plan shall either comply with sub. (1) (a) or (b) or have a contract with participating providers requiring the provider to notify all plan enrollees of the enrollees' rights under s. 609.24, Stats., if the provider's participation terminates for reasons other than provided in sub. (2) (a) or (b). The participating provider contracted with the insurer shall post a notification of termination with the plan no later than 30 days prior to the termination or 15 days following the date the insurer received the provider's termination notice, whichever is later, and describe each enrollee's options for receiving continued care from the

terminated provider. The insurer offering a preferred provider plan shall enforce the contract and ensure that enrollees are informed of a participating provider's termination.

(2) ~~A managed care~~ An insurer offering a defined network plan is not required to provide continued coverage for the services of a provider if either of the following is met:

(a) The provider no longer practices in the ~~managed care~~defined network plan's geographic service area.

(b) The insurer ~~issuing the managed care~~ offering a defined network plan terminates the provider's contract due to misconduct on the part of the provider.

(3) The ~~managed care~~ insurer offering a defined network plan shall make available to the commissioner upon request all information needed to establish cause for termination of providers.

~~**(4)** Medicare + Choice plans are not subject to s. 609.24 (1) (e), Stats., in accordance with 42 USC 1395w-26 (3) (B) ii.~~

9.36 Gag clauses. **(1)** No contract between ~~a managed care~~ an insurer offering a defined network plan and a participating provider may limit the provider's ability to disclose information, to or on behalf of an enrollee, about the enrollee's medical condition.

(2) A participating provider may discuss, with or on behalf of an enrollee, all treatment options and any other information that the provider determines to be in the best interest of the enrollee and within the scope of the provider's professional license. ~~A managed care~~ An insurer offering a defined network plan may not penalize the participating provider nor terminate the contract of a participating provider because the provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of an enrollee. ~~A managed care~~ An insurer offering a defined network plan may not retaliate against a provider for advising an enrollee of treatment options that are not covered benefits under the plan.

9.37 Notice requirements. **(1)** PROVIDED INFORMATION. Prior to enrolling members, ~~managed care plans~~ insurers offering a defined network plan shall provide to prospective group or individual policyholders information on the plan including all of the following:

(2) PROVIDER DIRECTORIES. ~~Managed care plans~~Insurers offering a defined network plan shall make current provider directories available to enrollees upon enrollment, and no less than annually, following the first year of enrollment. Preferred provider plans shall also include the language of Appendix D.

(3) OBSTETRICIANS AND GYNECOLOGISTS. ~~Managed care plans~~Insurers offering a defined network plan that ~~permit~~premits obstetricians or gynecologists to serve as primary care providers shall clearly so state in enrollment materials. ~~Managed care plans~~Insurers offering a defined network plan that ~~limit~~limits access to obstetricians and gynecologists shall clearly so state in enrollment materials the process for obtaining referrals.

(4) STANDING REFERRAL CRITERIA. ~~Managed care plans~~Insurers offering a defined network plan other than a preferred provider plan shall make information available to their enrollees describing the criteria for obtaining a standing referral to a specialist, including under what circumstances and for what services a standing referral is available, how to request a standing referral~~;~~, and how to appeal a standing referral determination. For purposes of s. 609.22 (4), Stats., and this subsection, referral includes prior authorization for services ~~regardless of use or designation of a primary care provider~~if the insurer uses this or similar methods for denying standing referrals to specialists without just cause and with such frequency to indicate a general business practice, as determined by the commissioner.

SECTION 17. INS 9.38 (intro.) and 9.38 (4) (intro.) and (c) are amended to read:

9.38 Policy and certificate language requirements. Each policy form marketed or each certificate issued to an enrollee by ~~a managed care~~an insurer offering a defined network plan or limited service health organization plan shall contain all of the following:

(4) (intro.) DISCLOSURE OF PROCEDURES AND EMERGENCY CARE NOTIFICATION. ~~Managed care plans~~Insurers offering a defined network plan shall do all of the following in a manner consistent with s. 609.22, Stats.:

(c) Consistent with s. 609.22 (6), Stats., ~~a managed care~~ and s. Ins 9.32 (1) (d), an insurer offering a defined network plan may require enrollees to notify the insurer of emergency room usage, but in no case may the ~~managed care~~ insurer offering a defined network plan require notification less than 48 hours after receiving services or before it is medically feasible for the enrollee to provide the notice, whichever is later. ~~A managed care~~An insurer offering a defined network plan may impose no greater penalty than assessing a deductible that may not exceed the lesser of 50% of covered expenses for emergency treatment or $250.00 for failing to comply with emergency treatment notification requirements.

SECTION 18. INS 9.39 (4) is amended to read:

9.39 (4) ALTERNATIVE COVERAGE FOR DISENROLLED ENROLLEES**.** ~~A~~An insurer offering a health maintenance organization plan or limited service health organization ~~other than a Medicare + Choice~~ plan that has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar alternate insurance coverage to the enrollee. In the case of group certificate holders, the insurance coverage shall be continued until the affected enrollee finds his or her own coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

SECTION 19. INS 9.40 (title), (2), (3), (4), (6), (7) (intro.) and (8) are amended to read:

9.40 Required quality assurance and remedial action plans.

(2) (a) By April 1, 2000, an insurer, with respect to a ~~managed care~~defined network plan that is not a preferred provider plan~~, and by April 1, 2007, with respect to a preferred provider plan,~~ shall submit a quality assurance plan consistent with the requirements of s. 609.32, Stats., to the commissioner, except as provided in par. (b). The ~~plans~~ insurers shall submit a quality assurance plan that is consistent with the requirements of s. 609.32, Stats., by April 1 of each subsequent year. The quality assurance plan shall be designed to reasonably assure that health care services provided to enrollees of the ~~managed care~~defined network plan meet the quality of care standards consistent with prevailing standards of medical practice in the community. The quality assurance plan shall document the procedures used to train employees of the ~~managed care~~ defined network plan in the content of the quality assurance plan.

(b) Insurers offering a defined network plan that is not also a preferred provider plan or health maintenance organization plan shall submit a quality assurance plan consistent with the requirements of par. (a) and s. 609.32, Stats., to the commissioner by April 1, 2007, and April 1 of each subsequent year.

(3)~~(a) No later than October 1, 2003, and by October 1 each year prior to 2007, every insurer, with respect to a preferred provider plan, shall submit to the commissioner a quality assurance plan appropriate to the plan structure. The quality assurance plan shall be designed to reasonably assure that health care services provided to enrollees of the preferred provider plan meet the quality of care standards consistent with prevailing standards of medical practice in the community. The quality assurance program shall, to the extent it is reasonably given the nature of the direct and indirect arrangement with the providers and type of plan, be designed to assure the quality of services provided by the plan and participating providers. A preferred provider plan shall include in its quality assurance activities an analysis of the plan's grievances,~~

~~complaints and appeals, statistically credible administrative claims data and other data that is reasonably attainable. An insurer may:~~

~~1. Include other quality activities such as participant satisfaction surveys, community-based quality improvement collaborations or health initiatives.~~

~~2. Substitute a medical director or contracted medical advisor for the peer review process required under s. 609.32 (1) (f), Stats.~~

~~(b) An insurer, with respect to a preferred provider plan, shall also meet the requirements of s. 609.32 (2) (a), Stats., by October 1, 2002, including all of the following.~~

~~1. Meet the requirements of s. 609.32 (2) (b), Stats., every four years following initial selection of a provider, except that assessment of clinical outcomes is required only to the extent that the plan is reasonably able to measure such.~~

~~2. Direct appointment of a medical director or medical advisor is required only to the extent that the plan assumes direct responsibility for clinical protocols, quality assurance activities and utilization management policies. The insurer may contract for those services otherwise.~~

~~(c) An insurer, with respect to a preferred provider plan, may use the quality assurance plan of a health care provider group or another managed care plan to meet the requirements of par. (a) or (b) and the quality assurance requirements under s. 609.32, Stats., if all of the following apply:~~

~~1. The participating providers in the managed care plan are substantially the same as the participating providers in the health care provider group or managed care plan for which the quality assurance plan was developed.~~

~~2. The preferred provider plan develops a process to monitor, evaluate and remedy complaints and grievances specific to its health benefit plans and participating providers.~~

~~(a) An insurer, with respect to a preferred provider plan, shall:~~

~~1. By April 1, 2001, establish and file with the commissioner a written plan, including specific goals, activities and time frames to obtain those personnel and other resources, systems, and contractual arrangements by October 1, 2003, reasonably necessary to enable the insurer to carry out the plan described under par. (a) or provide a written plan for compliance with par. (a) or (b) as permitted under par. (c).~~

~~2. Not later than April 1 of each calendar year prior to 2004, submit a progress report on its actions implementing its plan to implement its quality assurance plan or to comply under par. (c).~~

~~(e) This subsection does not apply after March 31, 2007.~~Insurers offering a preferred provider plan shall develop procedures for taking effective and timely remedial action to address issues arising from quality problems including access to, and continuity of care from, participating primary care providers. The remedial action plan shall at least contain all of the following:

(a) Designation of a senior-level staff person responsible for the oversight of the insurer's remedial action plan.

(b) A written plan for the oversight of any functions delegated to other contracted entities.

(c) A procedure for the periodic review of services related to clinical protocols and utilization management performed by the insurer offering a preferred provider plan or by another contracted entity.

(d) Periodic and regular review of grievances, complaints and OCI complaints.

(e) A written plan for maintaining the confidentiality of protected information.

(f) Documentation of timely correction of access to and continuity of care issues identified in the plan. Documentation shall include all of the following:

1. The date of awareness that an issue exists for which a remedial action plan shall be initiated.

2. The type of issue that is the focus of the remedial action plan.

3. The person or persons responsible for developing and managing the remedial action plan.

4. The remedial action plan utilized in each situation.

5. The outcome of the remedial action plan.

6. The established time frame for re-evaluation of the issue to ensure resolution and compliance with the remedial action plan.

(4) All insurers~~, with respect to managed care plans, including preferred provider plans~~ offering a defined network plan, other than a preferred provider plan, shall establish and maintain a quality assurance committee and a written policy governing the activities of the quality assurance committee that assigns to the committee responsibility and authority for the quality assurance program. ~~A preferred provider plan shall require all~~ All complaints, OCI complaints, appeals and grievances relating to quality of care ~~to~~ shall be reviewed by the quality assurance committee.

(6) Beginning June 1, ~~2004~~2008, every ~~managed care~~insurer offering a defined network plan other than a health maintenance organization or preferred provider plan, shall submit the standardized data set designated by the commissioner and appropriate to the specific plan type for the previous calendar year to the commissioner no later than June 15 of each year.

(7) No later than April 1, 2001, ~~all managed care plans, including health maintenance organization plans shall:~~ with respect to an insurer offering a defined network plan that is a health maintenance organization plan, and by April 1, 2008, for insurers offering a defined network plan that is not also a preferred provider plan or health maintenance organization plan, shall do all of the following:

(8) Beginning April 1, 2000, an insurer offering any ~~managed care~~defined network plan shall submit an annual certification for each plan with the commissioner no later than April 1 of each year. The certification shall assert the type of plan and be signed by an officer of the company. OCI shall maintain for public review a current list of health benefit plans, categorized by type.

SECTION 20. Ins 9.40 (1) (c) is repealed.

SECTION 21: INS 9.41 is created to read:

9.41 Right of the commissioner to request OCI complaints be handled as grievances. An insurer offering a defined network or limited scope plan shall treat and process an OCI complaint as a grievance at the request of the commissioner. The commissioner will provide a written description of the OCI complaint to the insurer.

SECTION 22. INS 9.42 (1), (2), (3), (4) (intro.), (a) and (e), (5) (a), and (6) (a) are amended to read:

9.42 Compliance program requirements. (1) All insurers ~~writing managed care plans, , preferred provider plans and limited service health organization insurers,~~ offering a defined network or limited scope plan except to the extent otherwise exempted under this ~~rule~~chapter or by statute, are responsible for compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., applicable sections of this subchapter and other applicable sections including but not limited to s. Ins 9.07. Insurers~~,~~ offering a defined network

plan or limited scope plan, to the extent they are required to comply with those provisions, shall establish a compliance program and procedures to verify compliance. Nothing in this section shall affect the availability of the privilege established under s. 146.38, Stats.

(2) The insurers shall establish and operate a compliance program that provides reasonable assurance that:

(a) The insurer is in compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07.

(b) Any violations of ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter or any applicable sections including but not limited to s. Ins 9.07 are detected and timely corrections are taken by the insurer.

(3) The insurer's compliance program shall include regular internal audits, including regular audits of any contractors or subcontractors who perform functions relating to compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter or any applicable sections including but not limited to s. Ins 9.07.

(4) An insurer that materially relies upon another party to carry out functions under ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter or any applicable sections including but not limited to s. Ins 9.07, shall do all of the following:

(a) Contractually require the other party to carry out those functions in compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30, 609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07.

(e) Include and enforce contractual provisions requiring the other party to give the office access to documentation demonstrating compliance with ss. ~~609.15,~~ 609.22, 609.24, 609.30,

609.32, 609.34, ~~and~~ 609.36, and 632.83, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07 within 15 days of receipt of notice.

(5) (a) Any audits, and associated work papers of audits, conducted during the period of review relating to the business and service operation of the ~~managed care plan, preferred provider plan or limited service health organization~~ insurer offering a defined network or limited scope plan.

(6) (a) An access plan developed in accordance with s. Ins ~~9.34~~9.32 (1) and s. 609.22, Stats., requirements.

SECTION 23. INS 9.42 (9) is created to read:

9.42 (9) An insurer offering a preferred provider plan that is not also a defined network plan shall comply with this section to the extent applicable.

SECTION 24. Appendix D to ch. Ins 9 is created to read:

APPENDIX D. PREFERRED PROVIDER PLAN NOTICE TO ENROLLEES.

IMPORTANT NOTICE

You are strongly encouraged to contact us to verify the status of the providers involved in your care including, for example, the anesthesiologist, radiologist, pathologist, facility, clinic or laboratory, when scheduling appointments or elective procedures to determine whether each provider is a participating or nonparticipating provider. Such information may assist in your selection of provider(s) and will likely affect the level of co-payment, deductible and amount of co-insurance applicable to the care you receive. The information contained in this directory may change during your plan year. Please contact [insert 800 and direct dial phone number of insurer] to learn more about the participating providers in your network and the implications, including financial, if you decide to receive your care from nonparticipating providers.

SECTION 25. INS 18.03 (2) (c) 1. is amended to read:

18.03 (2) (c) 1. An insurer offering a health benefit plan that is a ~~managed care~~defined network plan as defined in s. 609.01 (~~3c~~1b), Stats., other than a preferred provider plan as defined in s. 609.01 (4), Stats., shall do all of the following:

SECTION 26. Effective date. This rule shall take effect on the first day of the first month following publication in the Wisconsin administrative register as provided in s. 227.22 (2) (intro.), Stats.

SECTION 27. Applicability date. This rule shall first apply to newly issued policies or certificates of insurance on or after January 1, 2007, and to policies renewed on or after January 1, 2008.

SECTION 28. Enforcement. This rule may be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

Dated at Madison, Wisconsin, this _____ day of _____, 2006.

Jorge Gomez
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Rule Ins 9 relating to defined network and preferred provider plans and may affect small businesses

This rule change will have no significant fiscal effect on the private sector regulated by OCI.

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2047 (R10/2000)

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 9**

Subject
Defined network and preferred provider plans

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	**Annualized Fiscal impact on State funds from:**	
A. State Costs by Category	**Increased Costs**	**Decreased Costs**
State Operations - Salaries and Fringes	**$ 0**	**$ -0**
(FTE Position Changes)	(**0** FTE)	(**-0** FTE)
State Operations - Other Costs	**0**	**-0**
Local Assistance	**0**	**-0**
Aids to Individuals or Organizations	**0**	**-0**
TOTAL State Costs by Category	**$ 0**	**$ -0**
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	**$ 0**	**$ -0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	**$ 0**	**$ -0**
GPR Earned	**0**	**-0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
TOTAL State Revenues	**$ 0 None**	**$ -0 None**

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ **None 0**	$ **None 0**
NET CHANGE IN REVENUES	$ **None 0**	$ **None 0**

Prepared by:	**Telephone No.**	**Agency**
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2048 (R10/2000)

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 9**

Subject

Defined network and preferred provider plans

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected:
   ☐ Towns ☐ Villages ☐ Cities
   ☐ Counties ☐ Others _____
   ☐ School Districts ☐ WTCS Districts

Fund Sources Affected
☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by:	**Telephone No.**	**Agency**
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)