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

Ins 3.48, 3.50, and 3.52 are repealed; to amend Ins 51.80 (2); to create Ins 3.39 (7) (g), Ins 3.39 (30) (r), Ins 3.67, Ins 6.11 (3) (b) 4., and ch. Ins 9, Wis. Adm. Code, relating to revising requirements for managed care plans, preferred provider plans and limited service health organization plans to comply with recent changes in state laws.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 609.38, and 632.85, Stats.

Statutes interpreted: ch. 609 and s. 632.85, Stats.

Most of these revisions are based on new requirements for managed care plans established in 1997 Wisconsin Act 237 and 1997 Wisconsin Act 155. Some of the requirements also apply to all group or individual health plans.

The definition of a managed care plan has been expanded to meet new statutory requirements. Medicare + Choice, Medicare Select, plans that either directly or indirectly contract for use of providers, and most forms of group or individual health insurance that create financial incentives for policyholders to use a specified provider or group of providers are included in this definition.

Financial requirements for health maintenance organizations and limited service health organizations have been repealed and recreated within ch. Ins 9.

Health maintenance organizations and limited service health organizations are required to submit quality assurance plans with their business plans.

The grievance procedures for managed care plans, preferred provider plans and limited service health organizations have been expanded to meet new statutory requirements and to improve the review process.

State statutes require managed care plans to ensure enrollees have reasonable access to health care providers. This rule outlines the method by which plans assure the commissioner that reasonable access will exist.

Managed care plans are required to ensure continuing access, for a reasonable period of time, to providers who were represented to enrollees as available at the time the enrollee joined the plan if the provider leaves the plan during the plan year.

Managed care plans are specifically not permitted to create contracts with providers that interfere with a provider's ability to communicate all medical treatment options to plan enrollees.

Managed care plans are required to develop quality assurance plans that are reported to the commissioner. Effective January 1, 2002, health maintenance organizations will be required to collect and report HEDIS data to the commissioner. Effective June 1, 2004, every managed care plan, other than a health maintenance organization plan, will be required to collect and report a standardized data set designated by the commissioner and appropriate to the specific plan type and report that data by June 15 of each year.

Managed care plans must disclose significant policy limitations both in the policy and to enrollees and must use policies that comply with all Wisconsin insurance mandates.

Disenrollment from a managed care plan is only permitted in limited circumstances.

All health care plans must provide enrollees with clear and timely explanations if experimental treatment is denied. All health care plans must also provide a process for appealing a plan decision to deny coverage of experimental treatment.

All health care plans, specifically including fixed indemnity and special disease insurance, are included in s. Ins 3.67. All health care plans must provide a process to permit a physician, on behalf of an enrollee who is denied drug or device coverage because the drug or device was not on a pre-approved list, an opportunity to appeal the denial of coverage.

It will be considered an unfair claims settlement practice to deny coverage of emergency room treatment based solely on the diagnosis of the patient. All health care plans that provide emergency care coverage must consider the presenting symptoms of the enrollee and use the "prudent layperson" standard to determine if treatment will be covered by the health care plan.

All managed care plans, preferred provider plans and limited service health organizations must establish a compliance program, as described in Ins 9.42, Wis. Adm. Code, incorporating procedures to verify compliance with the requirements of Ins 9.07 and Ins 9 subchapter III.

SECTION 1. Ins 3.48, 3.50, and 3.52 are repealed.

SECTION 2. Ins 51.80 (2) is amended to read:

Ins 51.80 (2). SCOPE. This section applies to all lines of insurance except title insurance and mortgage guarantee insurance as defined in s. Ins 6.75 (2) (h) and (i), and to each insurer subject to ss. 623.11 and 645.41, Stats., except insurers licensed under chs. 612, 615 or 616, Stats., insurers subject to ~~s. Ins 3.50 or 3.52~~ s. Ins 9.04 and life insurers domiciled in foreign countries.

SECTION 3. Ins 3.39 (7) (g) is created to read:

Ins 3.39 (7) (g). Insurers writing Medicare + Choice plans shall additionally comply with ch. Ins 9, subchapters I and III.

SECTION 4. Ins 3.39 (30) (r) is created to read:

Ins 3.39 (30) (r). Insurers writing Medicare Select policies shall additionally comply with ch. Ins 9, subchapters I and III.

SECTION 5. Ins 3.67 is created to read:

Ins 3.67 Benefit Appeals Under Certain Policies.

(1) DEFINITIONS. In this section:

(a) "Expedited request" means a request where the standard resolution process may include any of the following:

1. Serious jeopardy to the life or health of the enrollee or the ability of the enrollee to regain maximum function.

2. In the opinion of a physician with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. Is determined to be an expedited request by a physician with knowledge of the enrollee's medical condition.

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

(c) "Health care plan" has the meaning provided under s. 628.36 (2) (a) (1), Stats., including fixed indemnity and specified disease insurance but does not include coverage ancillary to property and casualty insurance and Medicare + Choice plans.

(d) "Limited service health organization" has the meaning provided under s. 609.01 (3), Stats.

(e) “Managed care plan” has the meaning provided under s. 609.01 (3c), Stats.

(f) “Self-insured plan” has the meaning provided under s. 632.85 (1) (c), Stats.

(2) DRUGS AND DEVICES. A health care plan or self-insured plan that provides coverage of only certain specified prescription drugs or devices shall develop a process through which an enrollee’s physician may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device.

(3) COVERAGE OF EXPERIMENTAL TREATMENTS. (a) Any coverage limitations for experimental treatment shall be defined and clearly disclosed in every policy issued by a health care plan or self-insured plan in accordance with s. 632.855 (2), Stats.

(b) A health care plan or self-insured plan that limits coverage for experimental treatment shall have an internal procedure consistent with s. 632.855 (3), Stats., including issuing a written coverage decision within 5 business days of receipt of the request.

(4) APPEAL PROCEDURE. The procedure for managed care plan enrollees to appeal a decision under sub. (2) and (3) is delineated under s. Ins 9.33. For other health care plans, the appeal procedure established under this section shall include all of the following:

(a) The opportunity for the policyholder or certificate holder, or an authorized representative of the policyholder or certificate holder, to submit a written request, which may be in any form and which may include supporting material, for review by the insurer of the denial of any benefits under the policy.

(b) If an insurer denies any benefit under sub. (2) or (3), the insurer shall, at the time the insurer gives notice of the denial of benefits, provide the policyholder with a written description of the appeal process.

(c) The health care plan or self-insured plan shall acknowledge, in writing, a request for review of coverage under sub. (2), within 5 business days of receiving it.

(d) Within 30 calendar days after receiving the request under sub. (2) or (3), the health care plan or self-insured plan shall provide the disposition of the review and notify the person who submitted the request for review of the results of the review.

(e) A process to resolve an expedited request for review as expeditiously as the health condition requires but not to exceed 72 hours from the receipt of a substantially completed request under sub. (2) or (3).

(f) An insurer shall describe the procedure established under this subsection in every policy, group certificate and outline of coverage issued in connection with a health care plan.

(g) Each insurer offering a health care plan shall keep together, at its home or principal office, all records of appeals under this subsection. The insurer shall make these records available for review during examinations or at the request of the commissioner.

SECTION 6. Ins 6.11 (3) (b) 4. is created to read:

Ins 6.11 (3) (b) 4. Violating the requirements established in s. 632.85, Stats.

SECTION 7. Ch. Ins 9 is created to read:

CHAPTER INS 9

Managed Care Plans
Subchapter I: Definitions

Ins 9.01 Definitions. In addition to the definitions in s. 609.01, Stats., in this chapter:

(1) "Acceptable letter of credit" means a clean, unconditional, irrevocable letter of credit issued by a Wisconsin bank or any other financial institution acceptable to the commissioner which renews on an annual basis for a 3–year term unless written notice of nonrenewal is given to the commissioner and the limited service health organization at least 60 days prior to the renewal date.

(2) "Commissioner" means the "commissioner of insurance" of this state or the commissioner's designee.

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

(4) "Expedited grievance" means a grievance where the standard resolution process may include any of the following:

(a) Serious jeopardy to the life or health of the enrollee or the ability of the enrollee to regain maximum function.

(b) In the opinion of a physician with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

(c) It is determined to be an expedited grievance by a physician with knowledge of the enrollee's medical condition.

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

(6) "Health benefit plan" has the meaning provided under s. 632.745 (11), Stats.

(7) "HMO" or "health maintenance organization" means a health care plan as defined in s. 609.01 (2), Stats.

(8) "Health maintenance organization insurer" has the meaning provided under s. 600.03 (23c), Stats.

(9) "Hospital emergency facility" means any hospital facility that offers services for emergency medical conditions as described in s. 632.85 (1) (a), Stats., within its capability to do so and in accordance with s. HFS 124.24, or the licensure requirements of the jurisdiction in which the hospital resides.

(10) "IPA" or "individual practice association" has the meaning provided under s. 600.03 (23g), Stats.

(11) "Limited service health organization" means a health care plan as defined in s. 609.01 (3), Stats.

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

(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.

(14) "Office" means the "office of the commissioner of insurance."

(15) "Preferred provider plan" has the meaning provided under s. 609.01 (4), Stats.

(16) "Primary provider" has the meaning provided under s. 609.01 (5), Stats.

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

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

(b) The only direct or indirect compensation arrangement the insurer has with the provider provides for compensation that is:

1. On a fee for service basis and not on a risk sharing basis, including, but not limited to, capitation, withholds, global budgets, or target expected expenses or claims;

2. The compensation arrangement provides for compensation that is not less than 80% of the provider's usual fee or charge.

(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 plan to the extent the provider submits the claim directly to the insurer.

(d) The provider is not directly or indirectly managed, owned, or employed by the insurer.

(e) The insurer does not disclose, market, advertise, provide a telephone service or number relating to, or include in policyholder or enrollee material information relating to, the availability of the compensation arrangement described under par. (b), or the names or addresses of the provider or an entity that maintains a compensation arrangement described under par. (b), except to the extent required by law in processing of explanation of benefits. The insurer may not indirectly cause or permit a prohibited disclosure and may not make any such disclosure in the course of utilization review or pre-authorization functions.

Subchapter II: Financial Standards for Health Maintenance Organizations or Limited Service Health Organizations.

Ins 9.02 Purpose. This subchapter establishes financial standards for health maintenance organizations and limited service health organizations doing business in Wisconsin. These requirements are in addition to any other statutory or administrative rule requirements that apply to health maintenance organizations and limited service health organizations.

Ins 9.03 Scope. This subchapter applies to all insurers writing health maintenance organization or limited service health organization business in this state.

Ins 9.04 Financial requirements. The following are the minimum financial requirements for compliance with this section unless a different amount is ordered by the commissioner:

(1) CAPITAL. Unless otherwise ordered by the commissioner the minimum capital or permanent surplus of:

(a) A health maintenance organization insurer first licensed or organized on or after July 1, 1989, is $750,000;

(b) A health maintenance organization insurer first licensed or organized prior to July 1, 1989, is $200,000;

(c) The minimum capital or permanent surplus requirement for an insurer licensed to write only limited service health organization business shall be not less than $75,000. The commissioner may accept the deposit or letter of credit under sub. (3) to satisfy the minimum capital or permanent surplus requirement under this par. (c), if the insurer licensed to write only limited service health organization business demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements.

(d) Any other insurer writing health maintenance organization or limited service health organization business, is the amount of capital or required surplus required under the statutes governing the organization of the insurer.

(2) COMPULSORY SURPLUS. (a) An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization or limited service health organization business, except for a health maintenance organization insurer or an insurer licensed to write only limited service health organization business, is subject to s. Ins 51.80.

(b) A health maintenance organization insurer shall maintain a compulsory surplus as follows, or a greater amount required by order of the commissioner: the greater of $750,000 or an amount equal to the sum of:

1. 10% of premiums earned in the previous 12 months for policies that include coverages that are considered other insurance business under s. 609.03 (3) (a) 3., Stats., plus;

2. 3% of other premium earned in the previous 12 months except that if the percentage of the liabilities of the health maintenance organization insurer that are covered liabilities is less than 90%, 6% of other premiums earned in the previous 12 months.

(c) Each insurer licensed to write only limited service health organization business shall maintain a compulsory surplus to provide security against contingencies that affect its financial position but which are not fully covered by provider contracts, insolvency insurance, reinsurance, or other forms of financial guarantees. The compulsory surplus shall be the greater of 3% of the premiums earned by the limited service health organization in the previous 12 months, or $75,000.

(d) The commissioner may accept a deposit of securities or letter of credit with the same terms and conditions as required under sub. (3) to satisfy the compulsory surplus requirement if the limited service health organization demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements. The commissioner may, by order, require a higher or lower compulsory surplus or may establish additional factors for determining the amount of compulsory surplus required for a particular limited service health organization.

(3) DEPOSIT OR LETTER OF CREDIT. Each limited service health organization shall maintain either a deposit of securities with the state treasurer or an acceptable letter of credit on file with the commissioner's office. The amount of the deposit or letter of credit shall be not less than $75,000 for limited service health organizations. The letter of credit shall be payable to the commissioner whenever rehabilitation or liquidation proceedings are initiated against the limited service health organization.

(4) RISKS. Risks and factors the commissioner may consider in determining whether to require greater compulsory surplus by order include, but are not limited to, those described under s. 623.11 (1) (a) and (b), Stats., and the extent to which the insurer effectively transfers risk to providers. A health maintenance organization insurer may transfer risk through any mechanism including, but not limited to, those provided under s. Ins 9.05 (4).

(5) SECURITY SURPLUS. (a) An insurer, including an insurer organized under ch. 613, Stats., writing health maintenance organization insurance or limited service health organization business, except for a health maintenance organization insurer or an insurer licensed to write only limited service health organization business, is subject to s. Ins 51.80.

(b) Health maintenance organization insurers and insurers licensed to write only limited service health organization business should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of a health maintenance organization insurer shall be the greater of:

1. Compulsory surplus plus 40% reduced by 1% for each $33 million of premium in excess of $10 million earned in the previous 12 months; or

2. 110% of its compulsory surplus.

(c) The security surplus of an insurer licensed to write only limited service health organization business shall be not less than 110% of compulsory surplus.

(6) INSOLVENCY PROTECTION FOR POLICYHOLDERS. (a) Each health maintenance organization insurer is required to either maintain compulsory surplus as required for other insurers under s. Ins 51.80 or to demonstrate that in the event of insolvency all of the following shall be met:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged.

2. Enrollees will be entitled to similar, alternate coverage that does not contain any medical underwriting or pre-existing limitation requirements.

(b) Each insurer licensed to write only limited service health organization business that provides hospital benefits shall demonstrate that, in the event of an insolvency, enrollees hospitalized at the time of an insolvency will be covered until discharged.

Ins 9.05 Business plan. All applications for certificates of incorporation and certificates of authority of a health maintenance organization insurer or an insurer licensed to write only limited service health organization business shall include a proposed business plan. In addition to the items listed in ss. 611.13 (2) and 613.13 (1), Stats., the following information shall be contained in the business plan:

(1) ORGANIZATION TYPE. (a) The type of health maintenance organization insurer, including whether the providers affiliated with the organization will be salaried employes, group contractors, or individual contractors.

(b) The type of limited service health organization insurer including:

1. The name and address of the insurer licensed to write only limited service health organization business and the names and addresses of individual providers, if any, who control the insurer licensed to write only limited service health organization business, and;

2. The type of organization, including information on whether providers will be salaried employes of the organization or individual or group contractors.

(2) FEASIBILITY STUDIES AND MARKETING SURVEYS. A summary of feasibility studies or marketing surveys that support the financial and enrollment projections for the health maintenance organization insurer or the insurer licensed to write only limited service health organization business. The summary shall include the potential number of enrollees in the operating territory, the projected number of enrollees for the first 5 years, the underwriting standards to be applied, and the method of marketing the organization.

(3) GEOGRAPHICAL SERVICE AREA. The geographical service area by county including a chart showing the number of primary and specialty care providers with locations and service areas by county; the method of handling emergency care, with locations of emergency care facilities; and the method of handling out–of–area services.

(4) PROVIDER AGREEMENTS. The extent to which any of the following will be included in provider agreements and the form of any provisions that do any of the following:

(a) Limit the providers' ability to seek reimbursement for covered services from policyholders or enrollees.

(b) Permit or require the provider to assume a financial risk in the health maintenance organization insurer, including any provisions for assessing the provider, adjusting capitation or fee–for–service rates, or sharing in the earnings or losses.

(c) Govern amending or terminating agreements with providers.

(5) PROVIDER AVAILABILITY. A description of how services will be provided to policyholders in each service area, including the extent to which primary care will be given by providers under contract with the health maintenance organization insurer.

(6) QUALITY ASSURANCE. A summary of comprehensive quality assurance standards that identify, evaluate and remedy problems related to access to care and continuity and quality of care. The summary shall address all of the following:

(a) A written internal quality assurance program.

(b) Written guidelines for quality of care studies and monitoring.

(c) Performance and clinical outcomes–based criteria.

(d) Procedures for remedial action to address quality problems, including written procedures for taking appropriate corrective action.

(e) Plans for gathering and assessing data.

(f) A peer review process.

(g) A process to inform enrollees on the results of the insurer's quality assurance program.

(h) Any additional information requested by the commissioner.

(7) PLAN ADMINISTRATION. A summary of how administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If management authority for a major corporate function is delegated to a person outside the organization, the business plan shall include a copy of the contract. Contracts for delegated management authority shall be filed for approval with the commissioner under ss. 611.67 and 618.22, Stats. The contract shall include all of the following:

(a) The services to be provided.

(b) The standards of performance for the manager.

(c) The method of payment including, any provisions for the administrator to participate in the profit or losses of the plan.

(d) The duration of the contract.

(e) Any provisions for modifying, terminating or renewing the contract.

(8) FINANCIAL PROJECTIONS. A summary of: current and projected enrollment; income from premiums by type of payor; other income; administrative and other costs; the projected break even point, including the method of funding the accumulated losses until the break even point is reached; and a summary of the assumptions made in developing projected operating results.

(9) FINANCIAL GUARANTEES. A summary of all financial guarantees by providers, sponsors, affiliates or parents within a holding company system, or any other guarantees which are intended to ensure the financial success of the health maintenance organization insurer. These include hold harmless agreements by providers, insolvency insurance, reinsurance or other guarantees.

(10) CONTRACTS WITH ENROLLEES. A summary of benefits to be offered enrollees including any limitations and exclusions and the renewability of all contracts to be written.

Ins 9.06 Changes in the business plan. **(1)** A health maintenance organization insurer or an insurer licensed to write only limited service health organization business shall file a written report of any proposed substantial change in its business plan. The insurer shall file the report at least 30 days prior to the effective date of the change. The office may disapprove the change. The insurer may not enter into any transaction, contract, amendment to a transaction or contract or take action or make any omission that is a substantial change in the insurer's business plan prior to the effective date of the change or if the change is disapproved. Substantial changes include changes in articles and bylaws, organization type, geographical service areas, provider agreements, provider availability, plan administration, financial projections and guarantees and any other change that might affect the financial solvency of the plan. Any changes in the items listed in Ins 9.05 (4) shall be filed under this section.

(2) A change in the quality assurance plan conducted in accordance with s. Ins 9.40 and s. 609.32, Stats., is not a reportable change in a business plan.

Ins 9.07 Copies of provider agreements. **(1)** Notwithstanding any claim of trade secret or proprietary information, all managed care plan insurers and limited service health organization insurers shall, upon request, make available to the commissioner all executed copies of any provider agreements between the insurer and subcontracts with individual practice associations or individual providers. Managed care plans, provider networks or independent practice associations 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.

(2) All health maintenance organization insurers or insurers licensed to write only limited service health organization business shall file with the commissioner, prior to doing business, copies of all executed provider agreements and other contracts covering liabilities of the health maintenance organization. For contracts with providers, a list of providers executing a standard contract and a copy of the form of the contract may be filed instead of copies of the executed contracts.

Ins 9.08 Other reporting requirements. **(1)** ANNUAL STATEMENT. All insurers authorized to write health maintenance organization business and insurers licensed to write only limited service health organization business shall file with the commissioner by March 1 of each year an annual statement for the preceding year. A health maintenance organization insurer shall use the current health maintenance organization annual statement blank prepared by the national association of insurance commissioners.

(a) A health maintenance organization insurer shall include with its annual statement a statement of covered expenses, and a special procedures opinion from a certified public accountant, in the form prescribed by the commissioner as appendix A.

(b) A health maintenance organization insurer shall file a quarterly report, including a report concerning covered expenses, in a form prescribed by the commissioner within 45 days after the close of each of the first 3 calendar quarters of the year unless the commissioner has notified the insurer that another reporting schedule is appropriate.

(c) A health maintenance organization insurer shall include with its annual audit financial reports filed under s. Ins 50.05 a statement of covered expenses and an audit opinion concerning the statement. Both the statement and opinion shall be in the form prescribed by the commissioner as appendix B and are due no later than May 1 of each year.

(2) QUARTERLY REPORT. An insurer writing health maintenance organization business, other than a health maintenance organization insurer, shall file a quarterly report in a form prescribed by the commissioner within 45 days after the close of each of the first 3 calendar quarters of the year unless the commissioner notifies the insurer that another reporting schedule is appropriate.

(3) PRESUMPTIONS. (a) If a health maintenance organization insurer fails to file a statement or opinion required under sub. (1) to (3) by the time required, it is presumed, in any action brought by the office within one year of the due date, that the health maintenance organization insurer is in financially hazardous condition and that the percentage of its liabilities for health care costs which are covered liabilities is and continues to be less than 65% for the purpose of s. 609.95, Stats.

(b) It is presumed that the percentage of liabilities that are covered liabilities of a health maintenance organization insurer is and continues to be not greater than the

percentage of covered expenses stated in the report or statement filed under sub. (1) to (3) for the most recent period.

(c) The health maintenance organization insurer has the burden of refuting a presumption under par. (a) or (b).

(4) ANNUAL STATEMENT FORM. An insurer licensed to write only limited service health organization business shall use the current Limited Service Health Organization annual statement blank prepared by the national association of insurance commissioners. All other insurers shall file an annual report in a form prescribed by the commissioner.

Note: The list of the forms described in (1) and (4) may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison, WI 53707-7873.

Ins 9.09 Notice of election and termination of hold harmless. **(1)** A notice of election to be exempt from s. 609.91 (1) (b), Stats., or a notice of termination of election to be subject to s. 609.91 (1) (c), Stats., in accord with s. 609.925 (1), Stats., is effective only if filed on the form prescribed by the commissioner and if the form is properly completed.

(2) A notice of termination of election to be exempt from s. 609.91 (1) (b), Stats., in accord with s. 609.92 (4), Stats., or a notice of termination of election to be subject to s. 609.91 (1) (c), Stats., in accord with s. 609.925 (2), Stats., shall be filed on the form prescribed by the commissioner. Notices described in this subsection that are filed with the commissioner but are not on the prescribed form or are not properly completed are nevertheless effective.

(3) In accordance with s. 609.93, Stats., a provider may not exercise an election under ss. 609.92 or 609.925, Stats., separately from a clinic or an individual practice association with respect to health care costs arising from health care provided under a contract with, or through membership in, the individual practice association or provided through the clinic.

Ins 9.10 Receivables from affiliates. A receivable, note or other obligation of an affiliate to a health maintenance organization insurer and limited service health organization insurer shall be valued at zero by the insurer for all purposes including, but not limited to, the purpose of reports or statements filed with the office, unless the commissioner specifically approves a different value. The different value shall be not more than the amount of the receivable, note or other obligation which is fully secured by a security interest in cash or cash equivalents held in a segregated account or trust.

Ins 9.11 Receivables from Individual Practice Association ("IPA"). After December 31, 1990, a health maintenance organization insurer shall value receivables, notes or obligations of individual practice associations as defined under s. 600.03 (23g), Stats., at zero for all purposes including, but not limited to, the purpose of reports or statements filed with the office, unless the receivable, note or obligation is fully secured by a security interest in cash or cash equivalents held in a segregated account or trust.

Ins 9.12 Incidental or immaterial indemnity business in health maintenance organizations. **(1)** Except as provided by sub. (2), insurance business is not incidental or immaterial under s. 609.03 (3) (a) 3., Stats., if a health maintenance organization insurer issues coverage which is not typically included in a health maintenance organization or limited service health organization policy and the insurer does any of the following:

(a) Markets the policy containing the coverage.

(b) The total premium for policies containing the coverage exceeds or is projected to exceed 5% of total premium earned in any 12–month period.

(2) Insurance business is incidental or immaterial under s. 609.03 (3) (a) 3., Stats., if the business is written according to the terms of a specific business plan for issuance of coverage under s. 609.03 (3) (a) 3., Stats., and the business plan is approved in writing by the office. A request for approval to do business under this paragraph including, but not limited to, issuance of policies with point of service coverage, shall include a detailed business plan, a copy of the policy form, a detailed description of how the business will be marketed and premium volume controlled, and other information prescribed by the office. The total premium for policies containing coverages subject to this paragraph and policies issued under sub. (1) may not exceed 10% of premium earned or projected to be earned in any 12–month period.

(3) If the commissioner approves insurance business as incidental or immaterial the commissioner may also, by order under s. Ins 9.04 (2), require the insurer to maintain more than the minimum compulsory surplus.

(4) For the purpose of this section, any coverage that covers services by a provider other than a participating provider is not typically included in a health maintenance organization or limited service health organization policy, except coverage of emergency out–of–area services.

Ins 9.13 Summary. A health maintenance organization insurer shall use the form prescribed in appendix C to comply with s. 609.94, Stats.

Ins 9.14 Nondomestic HMO. No certificate of authority may be issued under ch. 618, Stats., to a person to do health maintenance organization or limited service health organization business in this state unless the person is organized and regulated as an insurer and domiciled in the United States.

Ins 9.15 Time period. In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

Subchapter III: Market Conduct Standards for Managed Care Plans.

Ins 9.30 Purpose. This subchapter establishes market conduct standards for insurers offering managed care plans, preferred provider plans and limited service health organizations doing business in Wisconsin. These requirements are in addition to any other statutory or administrative rule requirements that apply to insurers offering managed care plans, preferred provider plans or limited service health organizations.

Ins 9.31 Scope. This subchapter applies to all insurers providing managed care plans or limited service health organization plans 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 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 if the plan is filed with the commissioner and the commissioner determines that all of the following conditions are met:

(1) The coverage involves ancillary coverage with minimal cost controls, such as minimal cost controls involving vision, prescription cards or transplant centers.

(2) The cost controls are unlikely to significantly affect the pattern of practice.

(3) The exemption is consistent with the purpose of this subchapter.

Ins 9.32 Limited exemptions. (1) SILENT DISCOUNT. An insurer, with respect to a managed care plan:

(a) Is exempt from meeting the requirements under ss. 609.15, 609.22, 609.24, 609.32. 609.34 and 609.36, Stats., and ss. Ins 9.33, 9.34, 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, 9.35, 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 are exempt from meeting the requirements under ss. 609.22 (1) to (4) and (8), 609.32 and 609.34, Stats., ss. Ins 9.34 (2) (a) and (b), 9.40 (1) to (7), and 9.42 (6) and (7), with respect to a managed care plan, if the insurer meets all of the following requirements.

(a) The managed care plan provides comprehensive benefits to insureds of at least 80% coverage for in-plan providers.

(b) The insurer's only financial incentive to the insureds to utilize participating providers is a co-insurance differential of not more than 10% between in-plan versus

off-plan providers. Except for the co-insurance differential of no greater than 10%, all benefits, deductibles and co-payments must be the same regardless of whether the insured obtains benefits, services or supplies from in-plan or off-plan providers.

(c) The insurer makes no representation regarding quality of care.

(d) The insurer makes no representation that the managed care plan is a preferred provider plan or that the 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 plan if participating or non-participating providers are utilized by an insured.

(e) The insurer, at the time an application is solicited, does all of the following.

1. Discloses to a potential applicant, and allows the applicant a reasonable opportunity to review, a directory which reasonably and clearly discloses the availability and location of providers:

a. Within reasonable travel distance from the principle location of the place of employment of employees likely to enroll under the plan, if the applicant is an employer; or

b. Within reasonable travel distance from the residence of the proposed insured, for any other application.

2. Obtains on the application, or on an addendum to the application, the applicant's signed acknowledgement that the applicant:

a. Has reviewed the disclosure under subd. 1;

b. Understands that participating providers may or may not be available to provide services and that the insurer is not required to make participating providers available; and

c. Understands that the plan will provide reduced benefits if the insured uses a non-participating provider.

3. Provides to each applicant a copy of the provider directory at the time the policy is issued.

4. The insurer provides access to translation services for the purpose of providing information concerning benefits, to the greatest extent possible, if a significant number of enrollees of the plan customarily use languages other than English.

Ins 9.33 Grievance procedure. **(1)** (a) DEFINITION AND EXPLANATION OF THE GRIEVANCE PROCEDURE. Each managed care plan, limited service health organization plan and preferred provider plan shall incorporate within its policies, certificates or outline of coverage, if required, the definition of a grievance in s. Ins 9.01 (5). The managed care plan, preferred provider plan or limited service health organization plan

shall develop an internal grievance procedure that shall be described in each policy and certificate issued to enrollees at the time of enrollment or issuance. In accord with s. 609.15 (1) (a), Stats., managed care plans, preferred provider plans and limited service health organization plan shall investigate each grievance.

(b) Insurers issuing Medicare + Choice plans shall follow the Medicare + Choice grievance and appeal procedures in accordance with 42 CFR s. 422.561 (1998), unless the insurer determines that a grievance or appeal is not subject to 42 CFR s. 422.561 (1998) and then the insurer shall follow the procedures set forth in this section.

(2) NOTIFICATION OF RIGHT TO APPEAL DETERMINATION. In addition to the notice requirement under sub. (1), each time the managed care plan, preferred provider plan or limited service health organization plan denies a claim or benefit or initiates disenrollment proceedings, the managed care plan, preferred provider plan or limited service health organization plan shall notify the affected enrollee of their right to file a grievance. For purposes of this subsection, denial or refusal of an enrollee's request for a referral from the insurer shall be considered a denial of a claim or benefit. When notifying an enrollee of their right to grieve the determination, the managed care plan, preferred provider plan or limited service health organization plan shall either direct the enrollee to the certificate section that delineates the procedure for filing a grievance or shall describe, in detail, the grievance procedure to the enrollee. The notification shall state the specific reason for the denial or initiation.

(3) ACKNOWLEDGMENT OF RECEIPT OF GRIEVANCE. The managed care plan, preferred provider plan or limited service health organization plan shall, within 5 business days of receipt of a grievance, deliver or deposit in the mail to the grievant a written acknowledgment of receipt of the grievance.

(4) TIMELINESS OF NOTIFICATION AND RESOLUTION OF GRIEVANCE. The managed care plan, preferred provider plan or limited service health organization plan shall resolve a grievance within 30 calendar days of receiving the grievance. If the managed care plan, preferred provider plan or limited service health organization plan is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if all of the following are met:

(a) The managed care plan, preferred provider plan or limited service health organization plan notifies, in writing, the person who filed the grievance that the managed care plan, preferred provider plan or limited service health organization plan has not resolved the grievance.

(b) The managed care plan, preferred provider plan or limited service health organization notifies the person who filed the grievance when resolution of the grievance may be expected.

(c) The managed care plan, preferred provider plan or limited service health organization notifies the person who filed the grievance of the reason additional time is needed.

(5) GRIEVANCE PROCEDURE. A grievance procedure shall include all of the following:

(a) A method whereby the enrollee who filed the grievance, or the enrollee's authorized representative, has the right to appear in person before the grievance panel to present written or oral information. The managed care plan, preferred provider plan or limited service health organization shall permit the grievant to submit written questions to the person or persons responsible for making the determination that resulted in the grievance unless the managed care plan, preferred provider plan or limited service organization permits the grievant to meet with and question the decision maker or makers.

(b) The managed care plan, preferred provider plan or limited service health organization plan shall inform the enrollee, in writing, of the time and place of the meeting at least 7 calendar days before the meeting.

(c) The managed care plan, preferred provider plan or limited service health organization plan shall provide reasonable accommodations to allow the enrollee who filed the grievance, or the enrollee's authorized representative, to participate in the meeting.

(d) In addition to the requirements of s. 609.15 (2) (b), Stats., the grievance panel shall not include the person or persons who ultimately made the initial denial determination. The panel may include no more than 1 of the person or persons' subordinates only if the panel consists of at least three persons. The panel may, however, consult with that person or persons.

(e) The enrollee member of the panel shall not be an employee of the plan to the extent possible.

(f) The panel may consult with a licensed health care provider with expertise in the field relating to the grievance.

(g) The panel's written decision to the grievant as described in s. 609.15 (2) (d), Stats., shall be signed by one member of the panel and include a written description of position titles of panel members involved in making the decision.

(6) EXPEDITED GRIEVANCE PROCEDURE. Subs. (3) to (5) do not apply to situations where the normal duration of the grievance resolution process could have adverse health effects for the enrollee. For these situations, the managed care plan, preferred provider plan and limited service health organization plan shall develop a separate expedited grievance procedure for expedited grievance situations and inform the enrollees of this procedure at the time of enrollment. This procedure shall require a managed care plan, preferred provider plan or limited service health organization plan to resolve an expedited grievance as expeditiously as the enrollee's health condition requires but not more than 72 hours after receipt of a grievance.

(7) REPORTING REQUIREMENTS. The managed care plan, preferred provider plan and limited service health organization plan shall record, retain, and report records for each complaint and grievance in accordance with all of the following requirements:

(a) Each record of each complaint and grievance submitted to the managed care plan, preferred provider plan or limited service health organization shall be kept and retained for a period of at least three years.

(b) Each provider contract and administrative services agreement entered into between a managed care plan, preferred provider plan or limited service health organization plan and a provider shall contain a provision under which the provider must identify complaints and grievances in a timely manner and forward these complaints and grievances in a timely manner to the managed care plan, preferred provider plan or limited service health organization for recording and resolution.

(c) The managed care plan, preferred provider plan or limited service health organization plan shall submit a grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on all grievances received during the previous calendar year. The report shall be in a form prescribed by the commissioner and, at a minimum, shall classify grievances into the following categories:

1. Plan administration including plan marketing, policyholder service, billing, underwriting, or similar administrative functions.

2. Benefit services including denial of a benefit, quality of care, refusal to refer enrollees or to provide requested services.

(d) Each insurer offering a managed care plan, preferred provider plan or limited service health organization plan shall maintain, at its home or principal office, all records on complaints and grievances. The insurer shall make these records available for review during examinations by or on request of the commissioner.

(8) MEDICARE + CHOICE REPORTING REQUIREMENTS. Medicare + Choice plans shall report to the commissioner the number of appeal requests received as required by the Health Care Financing Administration and any other information the commissioner may request.

(9) COMMISSIONER ANNUAL REPORT. The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from managed care plans, preferred provider plans and limited service health organization plans. The report shall also summarize OCI complaints involving the managed care plan, preferred provider plan and limited service health organization plan that were received by the office during the previous calendar year.

Note: A copy of the grievance experience report form OCI26-007, required under par. (7) (c), may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison WI 53707-7873.

Ins 9.34 Access standards (1) ANNUAL CERTIFICATION. An insurer offering a managed care plan shall file a certification with the commissioner within 3 months after the effective date of this rule, and thereafter, no later than August 1 of each year shall submit an annual certification to the commissioner demonstrating compliance with the access standards of this section and with s. 609.22, Stats., and s. Ins 9.32 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) ADDITIONAL REQUIREMENTS. An insurer offering a managed care plan shall have the capability to:

(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 participating provider for authorization for care which is covered by the plan.

Note: A copy of the annual certification form may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison, WI 53707-7873.

Ins 9.35 Continuity of care. **(1)** In addition to the requirements of s. 609.24, Stats., a managed care plan shall do either of the following:

(a) Upon termination of a provider from a managed care plan, the 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 shall comply with the following as appropriate:

1. If the terminating provider is a primary provider and the managed care plan requires enrollees to designate a primary provider, the plan shall notify each enrollee who designated the terminating provider of the termination the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice 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 plan requires a referral, the plan shall notify each enrollee authorized by referral to receive care from the specialist of the termination the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice 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 plan does not require a referral, the provider's contract with the plan 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 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice.

(b)1. Upon termination of a provider from a managed care plan, the 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 receives less than 30 days notice. A managed care plan shall provide information on substitute providers to all affected enrollees.

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

(2) A managed care plan is not required to provide continued coverage for the services of a provider if either of the following are met:

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

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

(3) The managed care 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.

Ins 9.36 Gag clauses. **(1)** No contract between a managed care 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 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 plan may not retaliate against a provider for advising an enrollee of treatment options that are not covered benefits under the plan.

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

(a) Covered services.

(b) A definition of emergency and out-of-area coverage.

(c) Cost sharing requirements.

(d) Enrollment procedures.

(e) Limitations on benefits including limitations on choice of providers and the geographical area serviced by the plan.

(2) PROVIDER DIRECTORIES. Managed care plans shall make current provider directories available to enrollees upon enrollment, and no less than annually, following the first year of enrollment.

(3) OBSTETRICIANS AND GYNECOLOGISTS. Managed care plans that permit obstetricians or gynecologists to serve as primary providers shall clearly so state in enrollment materials. Managed care plans that limit access to obstetricians and gynecologists shall clearly state in enrollment materials the process for obtaining referrals.

(4) STANDING REFERRAL CRITERIA. Managed care plans 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.

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

(1) DEFINITIONS. A definition of geographical service area, emergency care, urgent care, out–of–area service, dependent and primary provider, if these terms or terms of similar meaning are used in the policy or certificate and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the policy or certificate if such definition is adequately described in an attachment that is given to all enrollees along with the policy or certificate.

(2) DISCLOSURE OF EXCLUSIONS, LIMITATIONS AND EXCEPTIONS. Clear disclosure of any provision that limits benefits or access to services in the exclusions, limitations, and exceptions sections of the policy or certificate. Among the exclusions, limitations and exceptions that shall be disclosed are those relating to:

(a) Emergency and urgent care.

(b) Restrictions on the selection of primary or referral providers.

(c) Restrictions on changing providers during the contract period.

(d) Out–of–pocket costs including copayments and deductibles.

(e) Any restrictions on coverage for dependents who do not reside in the service area.

(3) DISCLOSURE OF MANDATED BENEFITS. Clear disclosure of all benefit mandates outlined in Wisconsin statutes.

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

(a) Provide a description of the procedure for an enrollee to obtain any required referral, including the right to a standing referral, and notice that any enrollee may request the criteria for the standing referral.

(b) Provide a description of the procedure for any enrollee to obtain a second opinion from a participating plan provider consistent with s. 609.22 (5), Stats.

(c) Consistent with s. 609.22 (6), Stats., a managed care plan may require enrollees to notify the insurer of emergency room usage, but in no case may the managed care 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 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.

Ins 9.39 Disenrollment. **(1)** DISCLOSURE. The health maintenance organization or limited service health organization shall clearly disclose in the policy and certificate any circumstances under which the health maintenance organization or limited service health organization may disenroll an enrollee.

(2) ENROLLEE DISENROLLMENT CRITERIA. Except as provided in s. 632.897, Stats., the health maintenance organization or limited service health organization may only disenroll an enrollee if one of the following occurs:

(a) The enrollee has failed to pay required premiums by the end of the grace period.

(b) The enrollee has committed acts of physical or verbal abuse that pose a threat to providers or other members of the organization.

(c) The enrollee has allowed a nonmember to use the health maintenance or limited service health organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage.

(d) The enrollee has moved outside of the geographical service area of the organization.

(e) The enrollee is unable to establish or maintain a satisfactory physician–patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee under this paragraph shall be permitted only if the health maintenance organization or limited service health organization can demonstrate that it did all of the following:

1. Provided the enrollee with the opportunity to select an alternate primary care physician.

2. Made a reasonable effort to assist the enrollee in establishing a satisfactory patient–physician relationship.

3. Informed the enrollee that he or she may file a grievance on this matter.

(3) PROHIBITED DISENROLLMENT CRITERIA. Notwithstanding sub. (2), the health maintenance organization or limited service health organization plan may not disenroll an enrollee for reasons related to any of the following:

(a) The physical or mental condition of the enrollee.

(b) The failure of the enrollee to follow a prescribed course of treatment.

(c) The failure of an enrollee to keep appointments or to follow other administrative procedures or requirements.

(4) ALTERNATIVE COVERAGE FOR DISENROLLED ENROLLEES**.** A health maintenance organization 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.

Ins 9.40 Required quality assurance plans. (1) In this section:

(a) "HEDIS data" means the elements of the Health Plan Employer Data and Information Set as defined by the National Committee on Quality Assurance.

(b) "Quality assurance" means the measurement and evaluation of the quality and outcomes of medical care provided.

(c) "Preferred provider plan" means a managed care plan that meets the definition in s. 609.01(4), Stats. A preferred provider plan does not include any of the following:

1. Coverage written in whole or in part by a health maintenance organization insurer as defined under s. 600.03(23c), Stats.

2. Coverage where an insurer provides a significant portion of services to its enrollees through direct or indirect risk transference contracts with providers, including but not limited to capitation, withholds, global budgets, or target expected expenses or claims.

3. Coverage which is marketed by an insurer as, or is, a health maintenance organization plan.

(2) By April 1, 2000, an insurer, with respect to a managed care 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. The plans 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 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 plan in the content of the quality assurance plan.

(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.

(d) 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.

(4) All insurers, with respect to managed care plans, including preferred provider plans, 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 complaints, appeals and grievances relating to quality of care to be reviewed by the quality assurance committee.

(5) Beginning June 1, 2002, every health maintenance organization shall submit the HEDIS data, or other standardized data set appropriate for health maintenance organizations designated by the commissioner, for the previous calendar year to the commissioner no later than June 15 or the HEDIS submission deadline established by the national committee for quality assurance of each year.

(6) Beginning June 1, 2004, every managed care plan other than a health maintenance organization 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:

(a) Include a summary of its quality assurance plan in its marketing materials.

(b) Include a brief summary of its quality assurance plan and a statement of patient rights and responsibilities with respect to the plan in its certificate of coverage or enrollment materials.

(8) Beginning April 1, 2000, an insurer offering any managed care 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.

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

(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, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07.

(b) Enforce the contractual provisions required under par. (a).

(c) Include in the insurer's compliance program provisions to monitor, supervise and audit the performance of the other party in carrying out the functions.

(d) Maintain management reports and records reasonably necessary to monitor, supervise and audit the other party's performance.

(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, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07 within 15 days of receipt of notice.

(f) Regularly audit compliance with contract provisions including audits of internal working papers and reports.

(5) The insurer shall maintain all of the following items in its records:

(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 plan.

(b) All provider directories and provider manuals for the period of review. The directory shall include, as an addendum, a list of all providers that disassociated with the insurer or provider network in the review period.

(c) A sample copy of the provider agreement, including those with a provider network, for each provider category including hospital, physician, medical clinic, pharmacy, mental health services and chiropractor.

(d) Copies of contracts for management services, data management and processing, marketing, administrative services and case management.

(e) A sample copy of each certificate form for the period of review including a copy of sample enrollment forms.

(6) Except as permitted under sub. (7), an insurer shall maintain a complete record of the following:

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

(b) A quality assurance plan developed in accordance with s. Ins 9.40 and s. 609.32, Stats., requirements including means of identification, evaluation and correction of quality assurance problems.

(c) Credentialing policies and procedures and a credentialing plan.

(d) Utilization management procedures and policies.

(e) Minutes from any committee, physician association, or board of directors meeting pertaining to quality assurance, utilization management, and credentialing.

(7) An insurer that complies with subs. (1) to (5), may permit another party to maintain any record required under sub. (6), but only if both of the following requirements are met:

(a) The insurer includes and enforces the contractual provision described in sub. (4) (e).

(b) The insurer produces any required record within 15 days after the office requests the record.

(8) An insurer shall maintain all of the following documents that relate to a silent provider network and shall make them available at the request of the commissioner:

(a) Provider and provider network agreements, including addenda addressing reimbursement and discounts.

(b) A listing of providers participating in additional group or individual discount contracts with the insurer.

(c) Policy form numbers of those insurance products with silent discounts and associated marketing materials.

(d) Claims administration guidelines for processing discounts including silent discounts.

(e) Detailed documentation and explanation of claim system data fields and codes that identify silent discounts, other discount calculations, usual and customary calculations, and billed and paid amounts.

Ins 9 Appendix A

AUDITOR'S SPECIAL PROCEDURES REPORT ON THE SCHEDULE OF COVERED EXPENSES

Board of Directors

XYZ Health Maintenance Organization Insurer

We have performed the following special procedures with respect to the Schedule of Covered Expenses for XYZ health maintenance organization insurer ("HMO insurer"), for the year ended December 31, XXXX. It is understood that this report is solely to assist you in complying with ch. Ins 9, Wis. Adm. Code, and ch. 609, Wis. Stats., and our report is not to be used for any other purpose. Our procedures and findings are as follows:

a. A randomly selected sample was taken from all medical and hospital expenses paid during the calendar year to test the attribute that the expenses reported on the provider's IRS 1099-MISC forms (or other supporting documentation for providers not issued an IRS-1099-MISC form) trace to the Schedule of Covered Expenses for those providers included on the Schedule of Covered Expenses.

b. A comparison was made between the Schedule of Covered Expenses and the Election of Exemption notices by providers to verify that providers which had given notice of their Election of Exemption prior to December 31, XXXX, and which had not also given notice of their Termination of Election prior to December 31, XXXX, are excluded from the Schedule of Covered Expenses.

A review of the assumptions and methods of the HMO insurer in establishing the amount of covered expenses included in the Incurred But Not Reported line of the Schedule of Covered Expenses was undertaken to determine if the company's estimate is reasonably estimated based on the HMO insurer's historical data and best information available to the HMO insurer.

Because the procedures do not constitute an examination made in accordance with generally accepted auditing standards, we do not express an opinion on any of the accounts or items referred to above. The following summarizes our findings as a result of the procedures referred to above.

FINDINGS REPORTED HERE

Had we performed any additional procedures, other matters might have come to our attention that would have been reported to you. This report relates only to the items specified above and does not extend to any financial statements of the HMO insurer taken as a whole.

____________________ __________________________

Date CPA Signature

Ins 9 Appendix B

AUDITOR'S REPORT ON THE SCHEDULE OF COVERED EXPENSES

Date

BOARD OF DIRECTORS

XYZ Health Maintenance Organization Insurer

We have audited, in accordance with generally accepted auditing standards, Financial Statements of XYZ health maintenance organization insurer ("HMO insurer"), for the year ended December 31, XXXX, and have issued our report thereon dated XXXXXXXXXX XX, XXXX. We have also audited the accompanying Schedule of Covered Expenses for XYZ HMO insurer as of December 31, XXXX. This schedule is the responsibility of management of XYZ HMO insurer. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the aforementioned schedule is free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the aforementioned schedule. An audit also includes assessing the accounting principles used and any significant estimates made by management, as well as evaluating the overall schedule presentations. We believe that our audit provides reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, covered expenses for the year ended December 31, XXXX.

________________________ ______________________________

Date CPA Signature

Ins 9 Appendix C

NOTICE

THIS NOTICE DESCRIBES HOLD-HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST HEALTH MAINTENANCE ORGANIZATION INSURER ENROLLEES FOR PAYMENT FOR SERVICES

Section 609.94, Wis. Stat., requires each health maintenance organization insurer ("HMO insurer"), to provide a summary notice to all of its participating providers of the statutory limitations and requirements in §§ 609.91 to 609.935, and § 609.97 (1), Wis. Stats.

SUMMARY

Under Wisconsin law a health care provider may not hold HMO insurer enrollees or policyholders ("enrollees") liable for costs covered under an HMO insurer policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the hold-harmless statutes only if the provider voluntarily "opts-in." An HMO insurer may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form in order to be effective.

HOLD HARMLESS

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not effect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy or certificate issued by the HMO insurer.

A. MANDATORY FOR HOLD HARMLESS. An enrollee of an HMO insurer is not liable to a health care provider for health care costs that are covered under a policy issued by that HMO insurer if any of the following are met:

1. Care is provided by a provider who is an affiliate of the HMO insurer, owns at least 5% of the voting securities of the HMO insurer, is directly or indirectly involved with the HMO insurer through direct or indirect selection of or representation by one or more board members, or is an Individual Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO insurer board members who directly or indirectly represent one or more IPAs or affiliates of IPAs.

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.

3. To the extent the charge exceeds the amount the HMO insurer has contractually agreed to pay the provider for that health care service.

4. The care is provided to an enrolled medical assistance recipient under a Department of Health and Family Services prepaid health care policy.

5. The care is required to be provided under the requirements of s. Ins 9.35, Wis. Adm. Code.

B. "OPT-OUT" HOLD HARMLESS.

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care meets any of the following:

1. Provided by a hospital or an IPA.

2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO insurer or are provided by a provider selected by the HMO insurer.

3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA that has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless. (See Exemptions and Elections, No. 4.)

C. "OPT-IN" HOLD HARMLESS.

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO insurer. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

CONDITIONS NOT AFFECTING IMMUNITY

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO insurer, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute).

2. A breach of or default on any agreement by the HMO insurer, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable.

3. The insolvency of the HMO insurer or any person contracting with the HMO insurer, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO insurer or other persons which would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless.

4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable.

5. Failure by the HMO insurer to provide notice to providers of the statutory hold-harmless provisions.

6. Any other conditions or agreement existing at any time.

EXEMPTIONS AND ELECTIONS

Hospitals, IPAs, and providers of physician services who may “opt-out” may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO insurer, the provider must within thirty (30) days after entering into that contract provide a notice to OCI of the provider’s election to be exempt from the statutory hold-harmless and recovery limitations for care under the contract.

2. If the hospital, IPA, or other provider does not have a contract with an HMO insurer, the provider must notify OCI that it intends to be exempt with respect to a specific HMO insurer and must provide that notice for the period January 1, 1990, to December 21, 1990, at least sixty (60) day before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least 90 days in advance.

3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.

4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions or the failure of the clinic to elect to be exempt applies to costs of health

care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.

5. The statutory hold-harmless “opt-out” provision applies to physician services only if the services are provided under a contract with the HMO insurer or if the physician is a selected provider for the HMO insurer, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless “opt-out” provision.

NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, HMO insurer, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at the Office’s current address:

P. O. Box 7873, Madison, WI 53707-7873

HMO INSURER CAPITAL AND SECURITY SURPLUS

Each HMO insurer is required to meet minimum capital and surplus standard (“compulsory surplus requirements”). These standards are higher if the HMO insurer has fewer than 90% of its liabilities covered by the statutory hold-harmless. Specifically, beginning January 1, 1992, the compulsory surplus requirement shall be at least the greater of $750,000 or 6% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are 90% or more. In addition to capital and surplus, an HMO insurer must also maintain a security surplus in the amount set by the Commissioner of Insurance.

FINANCIAL INFORMATION

An HMO insurer is required to file financial statements with OCI. You may request financial statements from the HMO insurer. OCI also maintains files of HMO insurer financial statements that can be inspected by the public.

SECTION 8. 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.

Dated at Madison, Wisconsin, this _______ day of __________________, 2000.

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Connie L. O'Connell
Commissioner of Insurance