State of Wisconsin
1995 - 1996 LEGISLATURE

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1995 ASSEMBLY BILL 1034

March 14, 1996 - Introduced by Representatives PROSSER, UNDERHEIM, SILBAUGH, KELSO, LADWIG, PORTER, GROTHMAN, OURADA, GREEN, OWENS, LAZICH, BALDUS, MUSSER, F. LASEE, MEYER, GOETSCH, LEHMAN, OTTE, TURNER, LORGE, OLSEN, DOBYNS, HAHN, FREESE, HUTCHISON, WIRCH, JOHNSRUD, KLUSMAN, HASENOHRL, SCHNEIDERS, ROBSON, PLACHE and SERATTI, cosponsored by Senators ROSENZWEIG, COWLES and BUETTNER. Referred to Committee on Rules.

AN ACT ***to amend*** 15.01 (4); and ***to create*** 15.107 (6) and 146.36 of the statutes; **relating to:** creating and specifying the powers and duties of the council on health care fraud and abuse.

Analysis by the Legislative Reference Bureau

This bill creates a 12-member council on health care fraud and abuse in the department of administration. Members of the council include persons with expertise in the medical assistance program and representatives of health insurers, employe benefit plan administrators, health maintenance organizations and law enforcement. The council is authorized to study all aspects of health care fraud and abuse, including the making of self-interested referrals and billing in excess of reasonable charges; to develop strategies to combat health care fraud and abuse by both health care providers and health care consumers; to examine problems relating to electronic claims for payment; to conduct public hearings concerning health care fraud and abuse; and to perform other tasks. The council must annually submit a report to the governor and to the legislature that, among other things, identifies different types of health care fraud and abuse and recommends specific proposed changes to state statutes or administrative rules to define the terms "health care fraud", "health care abuse" and "self-interested referral" and to combat health care fraud and abuse. Under the bill, council members are immune from civil liability and criminal prosecution for acts or omissions made in good faith within the scope of their duties as council members. The bill specifies that the council ceases to exist after December 30, 2000.

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

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

SECTION 1. 15.01 (4) of the statutes, as affected by 1995 Wisconsin Act 27, is amended to read:

15.01 **(4)** "Council" means a part–time body appointed to function on a continuing basis for the study, and recommendation of solutions and policy alternatives, of the problems arising in a specified functional area of state government, except the Milwaukee river revitalization council has the powers and duties specified in s. 23.18, the council on physical disabilities has the powers and duties specified in s. 46.29 (1) and (2) ~~and,~~ the state council on alcohol and other drug abuse has the powers and duties specified in s. 14.24 and, before January 1, 2001, the council on health care fraud and abuse has the powers and duties specified in s. 146.36.

SECTION 2. 15.107 (6) of the statutes is created to read:

15.107 **(6)** COUNCIL ON HEALTH CARE FRAUD AND ABUSE. (a) There is created a council on health care fraud and abuse which is attached to the department of administration under s. 15.03. The council consists of 12 members appointed for 3–year terms, at least one of whom shall have expertise in the medical assistance program and the remainder of whom shall include representatives of insurers, as defined in s. 146.36 (1) (d); employe benefit plan administrators; health maintenance organizations, as defined in s. 609.01 (2); and law enforcement.

(b) The governor shall designate one of the members to serve as chairperson of the council and shall establish the length of term for that office.

(c) The council shall meet at least twice annually.

(d) This subsection does not apply after December 30, 2000.

SECTION 3. 146.36 of the statutes is created to read:

146.36 Council on health care fraud and abuse. (1) In this section:

(a) "Agency" has the meaning given in s. 13.62 (2).

(b) "Council" means the council on health care fraud and abuse.

(c) "Health care provider" has the meaning given in s. 146.81 (1).

(d) "Insurer" means an insurer, as defined in s. 600.03 (27), that is authorized to do business in this state in one or more lines of insurance that includes health insurance.

(2) The council may do all of the following:

(a) Study all aspects of health care fraud and abuse, including the making of self–interested referrals and billing in excess of reasonable charges.

(b) Develop strategies to combat health care fraud and abuse by health care consumers and health care providers.

(c) Examine problems that relate to electronic claims for payment.

(d) Survey efforts of other states to reduce health care fraud and abuse.

(e) Collect information relevant to preparation of the report specified under sub. (3), from health care providers, insurers, employe benefit plan administrators, law enforcement agencies and other sources.

(f) Conduct public hearings concerning health care fraud and abuse.

(g) Engage in public information programs concerning health care fraud and abuse.

(h) Receive, for deposit in the council's account under s. 20.505 (4) (gm), gifts, grants or bequests to fund its operating expenses.

(3) Annually, the council shall submit to the governor and, under s. 13.172 (2), to the legislature a report that does all of the following:

(a) Identifies different types of fraud and abuse perpetrated by health care consumers and health care providers, including different methods of billing in excess of reasonable charges by health care providers.

(b) Analyzes self–interested referrals that are made among health care providers.

(c) Lists successful prosecutions of health care fraud and activities to combat health care abuse, including billing in excess of reasonable charges, as identified in par. (a), that have been conducted in courts in this state or as contested cases under subch. III of ch. 227.

(d) Specifies activities conducted by the council to combat health care fraud and abuse, including billing in excess of reasonable charges, as identified in par. (a).

(e) Recommends specific proposed changes to state statutes or administrative rules to define terms and to combat health care fraud and abuse, including self–interested referrals, as analyzed in par. (b), and billing in excess of reasonable charges, as identified in par. (a).

(4) A council member shall be immune from civil liability and criminal prosecution for any act or omission done in good faith within the scope of his or her powers and duties under this section.

(5) This section does not apply after December 30, 2000.

SECTION 4. Nonstatutory provisions; administration.

(1) INITIAL APPOINTMENTS OF MEMBERS OF THE COUNCIL ON HEALTH CARE FRAUD AND ABUSE. Notwithstanding the length of terms specified in section 15.107 (6) (a) of the statutes, as created by this act, the initial members of the council on health care fraud and abuse shall be appointed for the following terms:

(a) Four members, for terms expiring on July 1, 1997.

(b) Four members, for terms expiring on July 1, 1998.

(c) Four members, for terms expiring on July 1, 1999.

(END)