State of Wisconsin
2021 - 2022 LEGISLATURE

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2021 ASSEMBLY BILL 1185

March 10, 2022 - Introduced by Representatives S. RODRIGUEZ, ANDERSON, ANDRACA, SINICKI, HAYWOOD, CONLEY, HEBL, SUBECK, CONSIDINE and SHELTON, cosponsored by Senators LARSON and JOHNSON. Referred to Committee on Rules.

AN ACT ***to create*** 609.045 of the statutes; **relating to:** insurance coverage and balance billing for certain health care services and granting rule-making authority.

Analysis by the Legislative Reference Bureau

This bill requires defined network plans, such as health maintenance organizations, and certain preferred provider plans and self-insured governmental plans that cover benefits or services provided in either an emergency department of a hospital or independent freestanding emergency department to cover emergency benefits without requiring a prior authorization determination and without regard to whether or not the health care provider providing the emergency medical services is a participating provider or facility. If the emergency medical services for which coverage is required are provided by a nonparticipating provider, the plan must 1) not impose a prior authorization requirement or other limitation that is more restrictive than if the service was provided by a participating provider, 2) not impose cost sharing on the enrollee that is greater than the cost sharing required if the service was provided by a participating provider, 3) calculate the cost-sharing amount to be equal to the amount that would have been charged if the service was provided by a participating provider, 4) provide, within 30 days of the provider's or facility's bill, an initial payment or denial notice to the provider or facility and then pay a total amount to the provider or facility that is equal to the amount by which the provider's or facility's rate exceeds the amount it received in cost sharing from the enrollee, and 5) count any cost-sharing payment made by the enrollee for the

emergency medical services toward any in–network deductible or out–of–pocket maximum as if the cost–sharing payment was made for services provided by a participating provider or facility. The provider or facility may not bill or hold liable an enrollee of the plan for any amount for the emergency medical service that is more than the cost–sharing amount that is determined as described in the bill for the emergency medical service.

For coverage of an item or service that is provided by a nonparticipating provider in a participating facility, a plan must 1) not impose a cost–sharing requirement for the item or service that is greater than the cost–sharing requirement that would have been imposed if the item or service was provided by a participating provider, 2) calculate the cost–sharing amount to be equal to the amount that would have been charged if the service was provided by a participating provider, 3) provide, within 30 days of the provider's bill, an initial payment or denial notice to the provider and then pay a total amount to the provider that is equal to the amount by which the provider's rate exceeds the amount it received in cost sharing from the enrollee, and 4) count any cost–sharing payment made by the enrollee for the emergency medical services toward any in–network deductible or out–of–pocket maximum as if the cost–sharing payment was made for services provided by a participating provider. A nonparticipating provider providing an item or service in a participating facility may not bill or hold liable an enrollee for more than the cost–sharing amount unless the provider provides notice and obtains consent as described in the bill. However, if the nonparticipating provider is providing an ancillary item or service that is specified in the bill and the commissioner of insurance has not specifically allowed balance billing for that item or service by rule, the nonparticipating provider providing the ancillary item or service in a participating facility may not bill or hold liable an enrollee for more than the cost–sharing amount.

A provider or facility that is entitled to a payment under the bill for an emergency medical service or other item or service may initiate open negotiations with the plan to determine the amount of payment. If the open negotiation period terminates without determination of the payment amount, the provider, facility, or plan may initiate the independent dispute resolution process as specified by the commissioner of insurance. If an enrollee of a plan is a continuing care patient, as defined in the bill, and is obtaining services from a participating provider or facility and the contract is terminated or the coverage of benefits is going to be terminated, the plan must notify an enrollee of the enrollee's right to elect to continue transitional care, provide the enrollee an opportunity to notify the plan of the need for transitional care, and allow the enrollee to continue to have the benefits provided under the plan under the same terms and conditions as would have applied without the termination until either 90 days after the termination notice date or the date on which the enrollee is no longer a continuing care patient, whichever is earlier.

This proposal may contain a health insurance mandate requiring a social and financial impact report under s. 601.423, stats.

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

SECTION 1. 609.045 of the statutes is created to read:

609.045 Balance billing; emergency medical services. (1) DEFINITIONS. In this section:

(a) "Emergency medical services" means emergency medical services for which coverage is required under s. 632.85 (2) and includes emergency medical services described under s. 632.85 (2) as if section 1867 of the federal Social Security Act applied to an independent freestanding emergency department.

(b) "Preferred provider plan," notwithstanding s. 609.01 (4), includes only any preferred provider plan, as defined under s. 609.01 (4), that has a network of participating providers and imposes on enrollees different requirements for using providers that are not participating providers.

(c) "Self–insured governmental plan" means a self–insured health plan of the state or a county, city, village, town, or school district that has a network of participating providers and imposes on enrollees in the self–insured health plan different requirements for using providers that are not participating providers.

(2) EMERGENCY MEDICAL SERVICES. A defined network plan, preferred provider plan, or self–insured governmental plan that covers any benefits or services provided in an emergency department of a hospital or emergency medical services provided in an independent freestanding emergency department shall cover emergency medical services in accordance with all of the following:

(a) The plan may not require a prior authorization determination.

(b) The plan may not deny coverage based on whether or not the health care provider providing the services is a participating provider or participating emergency facility.

(c) If the emergency medical services are provided to an enrollee by a provider or in a facility that is not a participating provider or facility, the plan complies with all of the following:

1. The emergency medical services are covered without imposing on an enrollee a requirement for prior authorization or any coverage limitation that is more restrictive than requirements or limitations that apply to emergency medical services provided by participating providers or in participating facilities.

2. Any cost–sharing requirement imposed on an enrollee for the emergency medical service is no greater than the requirements that would apply if the emergency medical service were provided by a participating provider or in a participating facility.

3. Any cost–sharing amount imposed on an enrollee for the emergency medical service is calculated as if the total amount that would have been charged for the emergency medical service if provided by a participating provider or in a participating facility is equal to the amount paid to the provider or facility that is not a participating provider or facility as determined by the commissioner.

4. The plan does all of the following:

a. No later than 30 days after the provider or facility transmits to the plan the bill for emergency medical services, sends to the provider or facility an initial payment or a notice of denial of payment.

b. Pays to the provider or facility a total amount that, incorporating any initial payment under subd. 4. a., is equal to the amount by which the rate for a provider

or facility that is not a participating provider or facility exceeds the cost–sharing amount.

5. The plan counts any cost–sharing payment made by the enrollee for the emergency medical services toward any in–network deductible or out–of–pocket maximum applied by the plan in the same manner as if the cost–sharing payment was made for an emergency medical service provided by a participating provider or in a participating facility.

(3) PROVIDER BILLING LIMITATION FOR EMERGENCY MEDICAL SERVICES; AMBULANCE SERVICES. A provider of emergency medical services or a facility in which emergency medical services are provided that is entitled to payment under sub. (2) may not bill or hold liable an enrollee for any amount for the emergency medical service that is more than the cost–sharing amount determined under sub. (2) (c) 3. for the emergency service. A provider of ambulance services that is not a participating provider under an enrollee's defined network plan, preferred provider plan, or self–insured governmental plan may not bill or hold liable an enrollee for any amount of the ambulance service that is more than the cost–sharing amount that the enrollee would be charged if the provider of ambulance services was a participating provider under the enrollee's plan.

(4) NONPARTICIPATING PROVIDER IN PARTICIPATING FACILITY. For items or services other than emergency medical services that are provided to an enrollee of a defined network plan, preferred provider plan, or self–insured governmental plan by a provider who is not a participating provider but who is providing services at a participating facility, the plan shall provide coverage for the item or service in accordance with all of the following:

(a) The plan may not impose on an enrollee a cost–sharing requirement for the item or service that is greater than the cost–sharing requirement that would have been imposed if the item or service was provided by a participating provider.

(b) Any cost–sharing amount imposed on an enrollee for the item or service is calculated as if the total amount that would have been charged for the item or service if provided by a participating provider is equal to the amount paid to the provider that is not a participating provider as determined by the commissioner.

(c) No later than 30 days after the provider transmits the bill for services, the plan shall send to the provider an initial payment or a notice of denial of payment.

(d) The plan shall make a total payment directly to the provider that provided the item or service to the enrollee that, added to any initial payment described under par. (c), is equal to the amount by which the out–of–network rate for the item or service exceeds the cost–sharing amount.

(e) The plan counts any cost–sharing payment made by the enrollee for the item or service toward any in–network deductible or out–of–pocket maximum applied by the plan in the same manner as if the cost–sharing payment was made for the item or service when provided by a participating provider.

(5) CHARGING FOR SERVICES BY NONPARTICIPATING PROVIDER; NOTICE AND CONSENT. (a) Except as provided in par. (c), a provider of an item or service that is entitled to payment under sub. (4) may not bill or hold liable an enrollee for any amount for the item or service that is more than the cost–sharing amount determined under sub. (4) (b) for the item or service unless the nonparticipating provider provides notice and obtains consent in accordance with all of the following:

1. The notice states that the provider is not a participating provider in the enrollee's defined network plan, preferred provider plan, or self–insured governmental plan.

2. The notice provides a good faith estimate of the amount that the provider may charge the enrollee for the item or service involved, including notification that the estimate does not constitute a contract with respect to the charges estimated for the item or service.

3. The notice includes a list of the participating providers at the facility that would be able to provide the item or service and notification that the enrollee may be referred to one of those participating providers.

4. The notice includes information about whether or not prior authorization or other care management limitations may be required before receiving an item or service at the participating facility.

5. The enrollee provides consent to the provider to be treated by the nonparticipating provider, and the consent acknowledges that the enrollee has been informed that the charge paid by the enrollee may not meet a limitation that the enrollee's defined network plan, preferred provider plan, or self–insured governmental plan places on cost sharing, such as an in–network deductible.

6. A signed copy of the consent described under subd. 5. is provided to the enrollee.

(b) To be considered adequate, the notice and consent under par. (a) shall meet one of the following requirements, as applicable:

1. If the enrollee makes an appointment for the item or service at least 72 hours before the day on which the item or service is to be provided, any notice under par.

(a) shall be provided to the enrollee at least 72 hours before the day of the appointment at which the item or service is to be provided.

2. If the enrollee makes an appointment for the item or service less than 72 hours before the day on which the item or service is to be provided, any notice under par. (a) shall be provided to the enrollee on the day that the appointment is made.

(c) A provider of an item or service that is entitled to payment under sub. (4) may not bill or hold liable an enrollee for any amount for the ancillary item or service that is more than the cost–sharing amount determined under sub. (4) (b) for the item or service, unless the commissioner specifies by rule that the provider may balance bill for the specified item or service, if the ancillary item or service is any of the following:

1. Related to an emergency medical service.

2. Anesthesiology.

3. Pathology.

4. Radiology.

5. Neonatology.

6. A item or service provided by an assistant surgeon, hospitalist, or intensivist.

7. Diagnostic service, including a radiology or laboratory service.

8. An item or service provided by a specialty practitioner that the commissioner specifies by rule.

9. An item or service provided by a nonparticipating provider when there is no participating provider who can furnish the item or service at the participating facility.

(6) NOTICE BY PROVIDER OR FACILITY. Beginning no later than January 1, 2022, a health care provider or health care facility shall make available, including posting

on an Internet site, to enrollees in defined network plans, preferred provider plans, and self–insured governmental plans notice of the requirements on a provider or facility under subs. (3) and (5), of any other applicable state law requirements on the provider or facility with respect to charging an enrollee for an item or service if the provider or facility does not have a contractual relationship with the plan, and of information on contacting appropriate state or federal agencies in the event the enrollee believes the provider or facility violates any of the requirements under this section or other applicable law.

(7) NEGOTIATION; DISPUTE RESOLUTION. A provider or facility that is entitled to receive an initial payment or notice of denial under sub. (2) (c) 4. a. or (4) (c) may initiate, within 30 days of receiving the initial payment or notice of denial, open negotiations with the defined network plan, preferred provider plan, or self–insured governmental plan to determine a payment amount for the emergency medical service or other item or service for a period that terminates 30 days after initiating open negotiations. If the open negotiation period under this subsection terminates without determination of a payment amount, the provider, facility, defined network plan, preferred provider plan, or self–insured governmental plan may initiate, within the 4 days beginning on the day after the open negotiation period ends, the independent dispute resolution process as specified by the commissioner. If the independent dispute resolution decision maker determines the payment amount, the party to the independent dispute resolution process whose amount was not selected shall pay the fees for the independent dispute resolution. If the parties to the independent dispute resolution reach a settlement on the payment amount, the parties to the independent dispute resolution shall equally divide the payment for the fees for the independent dispute resolution.

(8) CONTINUITY OF CARE. (a) In this subsection:

1. "Continuing care patient" means an individual who is any of the following:

a. Undergoing a course of treatment for a serious and complex condition from a provider or facility.

b. Undergoing a course of institutional or inpatient care from a provider or facility.

c. Scheduled to undergo nonelective surgery, including receipt of postoperative care, from a provider or facility.

d. Pregnant and undergoing a course of treatment for the pregnancy from a provider or facility.

e. Terminally ill and receiving treatment for the illness from a provider or facility.

2. "Serious and complex condition" means any of the following:

a. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, a condition that is life–threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.

(b) If an enrollee is a continuing care patient and is obtaining items or services from a participating provider or facility and the contract between the defined network plan, preferred provider plan, or self–insured governmental plan and the participating provider or facility is terminated or the coverage of benefits that include the items or services provided by the participating provider or facility are terminated by the plan, the plan shall do all of the following:

1. Notify each enrollee of the termination of the contract or benefits and of the right for the enrollee to elect to continue transitional care from the provider or facility under this subsection.

2. Provide the enrollee an opportunity to notify the plan of the need for transitional care.

3. Allow the enrollee to elect to continue to have the benefits provided under the plan under the same terms and conditions as would have applied to the item or service if the termination had not occurred for the course of treatment related to the enrollee's status as a continuing care patient beginning on the date on which the notice under subd. 1. is provided and ending 90 days after the date on which the notice under subd. 1. is provided or the date on which the enrollee is no longer a continuing care patient, whichever is earlier.

(9) RULE MAKING. The commissioner may promulgate any rules necessary to implement this section, including specifying the independent dispute resolution process. The commissioner may promulgate rules to modify the list of those items and services for which a provider may not balance bill under sub. (5) (c).

(END)