2019 DRAFTING REQUEST

Bill

For:	**Debra Kolste (608) 266-7503**	Drafter:	**elunder**
By:	**Maria**	Secondary Drafters:	
Date:	**9/19/2019**	May Contact:	

Same as LRB:

Submit via email: **YES**
Requester's email: **Rep.Kolste@legis.wisconsin.gov**
Carbon copy (CC) to: **tamara.dodge@legis.wisconsin.gov**
erika.lunder@legis.wisconsin.gov

Pre Topic:

No specific pre topic given

Topic:

Prohibiting balance billing and creating an arbitration system

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Submitted	Jacketed	Required
/?	elunder 10/3/2019	aernsttr 10/3/2019			
/P1	elunder 10/16/2019	csicilia 10/16/2019	dwalker 10/3/2019		State
/P2	elunder 11/18/2019	csicilia 11/18/2019	mbarman 10/16/2019		State
/P3	elunder 11/22/2019	csicilia 11/22/2019	lparisi 11/18/2019		State
/P4			dwalker		State

Vers.	Drafted	Reviewed	Submitted	Jacketed	Required
			11/22/2019		
/1			mbarman 2/12/2020	dwalker 2/12/2020	State

FE Sent For: **<END>**

At Intro.

State of Wisconsin
2019 - 2020 LEGISLATURE

LRB-4389/2
EKL:...

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** imposing disclosure and billing requirements for certain health care providers, creating an arbitration process and granting rule-making authority.

Analysis by the Legislative Reference Bureau

The bill requires the commissioner of insurance to promulgate rules to establish the arbitration process under which enrollees, plans, and out-of-network providers may submit billing disputes to an independent dispute resolution entity. Under the bill, an enrollee may not request arbitration if the amount for which he or she is financially responsible does not exceed $500 or, if the provider or health care facility complied with the disclosures requirements described above, is less than the good-faith estimate provided by the provider. The plan or provider may not use the arbitration process to dispute bills for certain emergency services that do not exceed a specified amount or services for which provider fees are subject by law to monetary limitations.

Once a dispute is filed, the independent dispute resolution entity has 30 days to determine a reasonable fee for the services provided to the enrollee by the out-of-network provider. If the dispute is between the plan and provider, each party submits what it thinks is a reasonable fee for the services, and the independent dispute resolution entity must choose one of those amounts. However, if the entity finds that both sides' amounts are unreasonable or that a settlement between the parties is likely, it may direct the plan and provider to attempt a good faith negotiation for settlement and, if they reach an agreement, the entity will select that amount as its final determination. If the dispute is between the enrollee and

provider, the independent dispute resolution entity determines a reasonable fee based upon factors that include whether there is a gross disparity between the fee billed by the provider and other fees charged by that provider; the provider's training and experience; and the circumstances and complexity of the particular case. The entity's determination is binding on the parties.

The bill provides that the losing party must pay the costs of the arbitration with two exceptions. First, if a settlement is reached between a plan and provider at the direction of the independent dispute resolution entity, the costs are evenly divided between the parties. Second, if the enrollee is the losing party and the commissioner determines that paying the costs would be a hardship for the enrollee, the commissioner provides for the payment of the costs.

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:

INS 2-1 →

(b) *Plans and providers.* If there is a dispute over a payment under sub. (4) (a) 2. or (b) 1. or (5) (b), the plan or provider may submit the dispute for arbitration under this subsection, except that a dispute involving any of the following may not be submitted:

1. Services for which provider fees are subject by law to schedules or other monetary limitations.

2. Emergency services billed under American Medical Association Current Procedural Terminology codes 99217 to 99220, 99224 to 99226, 99234 to 99236, 99281 to 99285, 99288, and 99291 to 99292 if the amount billed for a specific code does not exceed 120 percent of the usual and customary cost for the code and does not exceed the exemption amount. The exemption amount shall be $600 in 2020 and shall be adjusted annually by the commissioner to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor, for the 12 months ending on December 31 of the preceding year, except that the exemption amount may not exceed $1,200.

(c) *Establishment.* The commissioner shall establish an arbitration process to resolve disputes that are submitted under this subsection. The commissioner shall certify at least one independent dispute resolution entity to conduct the arbitration process. In order to obtain and maintain certification, an independent dispute resolution entity shall use licensed providers who are in active practice in the same or similar specialty as the provider providing the service subject to dispute and who, to the extent practicable, are licensed in this state. The commissioner shall, by rule, establish a process for submitting a dispute for arbitration and standards for the arbitration process, including a process for certifying an independent dispute resolution entity and revoking the certification when appropriate.

(d) *Arbitration process.* When a party submits a dispute for arbitration under this subsection, the independent dispute resolution entity shall determine the amount of a reasonable fee for the services provided by the provider to the enrollee according to the conditions of this paragraph. The independent dispute resolution entity shall provide the determination, in writing, to the parties and the commissioner no later than 30 days after the dispute is submitted to the entity.

1. For a dispute described in par. (a), the independent dispute resolution entity shall determine if the fee charged by the provider to the enrollee is reasonable based on the factors in par. (e). If the entity determines the fee is reasonable, the entity shall select that amount as its determination. If the entity determines the fee is not reasonable, the entity shall determine a reasonable fee based on the factors in par. (e).

2. For a dispute described in par. (b), the plan and provider shall each submit an amount to the independent dispute resolution entity, and the entity shall select one of the amounts based on the factors in par. (e); except that, if the entity

determines that the amounts submitted by the parties are unreasonable or that a settlement between the parties is reasonably likely, the entity may direct the parties to attempt a good faith negotiation for settlement. If the plan and provider agree to an amount, the independent dispute resolution entity shall select that amount as its determination.

(e) *Reasonable fee criteria.* The independent dispute resolution entity shall consider all of the following factors when determining a reasonable fee under par. (d):

1. The provider's usual charge for comparable services rendered to patients covered by plans for which the provider is not in network.

2. Whether there is a gross disparity between the fee billed by the provider as compared to fees paid to that provider for the same services rendered to other patients covered by plans for which the provider is not in network and, in the case of a dispute described in or submitted under par. (b), fees paid by the plan to reimburse similarly qualified providers who are not in the plan's network.

3. The level of training, education, and experience of the provider.

4. The circumstances and complexity of the particular case, including time and place of the service.

5. Individual characteristics of the enrollee.

6. The usual and customary cost of the service.

7. Any factors identified by the commissioner by rule.

8. Any factors the entity determines are relevant based on the specific facts and circumstances of the dispute.

(f) *Binding effect.* The determination of the independent dispute resolution entity shall be binding on the parties to the dispute and shall be admissible in a court

proceeding between them and in any administrative proceeding between this state and the provider.

(g) *Costs.* For disputes described in par. (d) 1., the costs for the arbitration process shall be paid by the enrollee if the independent dispute resolution entity determines that the fee charged by the provider to the enrollee is reasonable and by the provider if the entity determines that the fee is not reasonable; except that the commissioner may waive or reduce the costs charged to the enrollee if requiring full payment would impose a hardship on the enrollee. The commissioner shall, by rule, specify the factors to be considered in making the determination of hardship and provide for the payment of costs in cases of hardship. For disputes described in par. (d) 2., the costs for the arbitration process shall be paid by the party whose amount is not selected by the independent dispute resolution entity or, if a settlement is reached, by both parties in equal amounts.

(END)

INSERTS

State of Wisconsin
2019 - 2020 LEGISLATURE

LRB-3521/1
EKL:cjs

2019 ASSEMBLY BILL 329

July 3, 2019 - Introduced by Representatives KOLSTE, EMERSON, ANDERSON, BOWEN, CONSIDINE, OHNSTAD, SARGENT, SHANKLAND, SINICKI, SUBECK, C. TAYLOR and VRUWINK, cosponsored by Senators SMITH, MILLER and RINGHAND. Referred to Committee on Health.

AN ACT ***to create*** 609.07 of the statutes; **relating to:** billing practices for certain health care providers and granting rule-making authority.

Analysis by the Legislative Reference Bureau

This bill creates disclosure, notice, billing, and mediation requirements for the situation in which an enrollee in a defined network plan or preferred provider plan may receive services from a health care provider that is not in the plan's network. Under the bill, a defined network plan or a preferred provider plan must annually provide to enrollees a directory of providers and a list of health care facilities that are in its network.

The bill also requires that a provider who is not in the network of the enrollee's plan but is providing a service at an in-network health care facility must disclose that information to the enrollee, provide the enrollee a good-faith estimate of the cost of services the enrollee may be responsible for, and inform the enrollee of the availability of mediation to settle disputes over the cost of services. In particular, the enrollee is entitled to mediation for a claim if the amount that the enrollee is financially responsible for, after copayments, deductibles, and coinsurance, is more than $500. The enrollee is not entitled to mediation if the out-of-network provider provides the required disclosure and the amount the enrollee is financially responsible for is less than the good-faith estimate provided by the provider. The health care facility may opt to provide the notice for the provider.

Under the bill, if an enrollee of a defined network plan or preferred provider plan requires medically necessary services that are not available from an in-network provider within a reasonable time, then the plan must provide an

opportunity for referral to an out-of-network provider. The plan must reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid had the provider been in the plan's network. The bill requires the enrollee to provide the out-of-network provider an assignment of benefits for any service, item, or supply provided by that provider.

Similarly, under the bill, if an enrollee of a defined network plan or preferred provider plan receives emergency services from an out-of-network provider, then the plan must reimburse the provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid if the provider was in the plan's network.

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

SECTION 1. 609.07 of the statutes is created to read:

609.07 Balance billing. (1) DEFINITIONS. In this section:

(a) "Assignment of benefits" means a written instrument signed by an insured or the authorized representative of an insured that assigns to a provider the insured's claim for payment, reimbursement, or benefits under a disability insurance policy as defined in s. 632.895 (1) (a).

(b) "Emergency services" means those services required to treat and stabilize an emergency medical condition in accordance with 42 USC 1395dd and services originating in a hospital emergency department, a freestanding emergency department, or a similar facility following treatment or stabilization of an emergency medical condition.

(c) "Network" means the providers that are under contract with a defined network plan or preferred provider plan to provide services to enrollees at an agreed price, for which the provider receives reimbursement in accordance with the contract.

(2) NOTICE OF NETWORK STATUS. (a) A defined network plan or preferred provider plan shall provide, no less frequently than annually, a list of health care facilities that have agreed to facilitate the usage of providers that are in the plan's network. The list shall specify the percentage of providers at those health care facilities that are not in the plan's network.

(b) A defined network plan or preferred provider plan shall provide, no less frequently than annually, a directory of all providers that are in the plan's network and are under contract with health care facilities that are in the plan's network. In the directory, the defined network plan or preferred provider plan shall specify health care facilities that do not have contracts with providers in a particular specialty.

(3) DISCLOSURES. (a) A provider that is not in a defined network plan's or preferred provider plan's network and is under contract to provide services at a health care facility that is in the plan's network shall provide, in writing, to an enrollee of the defined network plan or preferred provider plan all of the following:

1. That the enrollee may receive services from a provider that is not in the defined network plan's or preferred provider plan's network.

2. A good faith estimate of the enrollee's financial responsibility for the services provided under subd. 1.

3. That the enrollee is entitled to mediation under circumstances described in sub. (6).

(b) In lieu of the provider providing the notice under par. (a), a health care facility may provide the notice described under par. (a).

(4) EMERGENCY SERVICES. (a) If an enrollee of a preferred provider plan that restricts or increases cost sharing for use of providers that are not in its network

obtains emergency services from a provider not in the plan's network, the preferred provider plan shall do all of the following:

1. Allow the enrollee to obtain services from the provider until the enrollee can be transferred to a provider that is in the preferred provider plan's network in accordance with 42 USC 1395dd.

2. Reimburse the provider at the usual and customary rate or at a rate agreed to by the provider and the preferred provider plan.

3. Require the enrollee to pay an amount for the emergency services that is no more than the enrollee would have paid if the provider had been in the preferred provider plan's network.

(b) If an enrollee of a defined network plan obtains emergency services from a provider that is not in the plan's network, the defined network plan shall do all of the following:

1. Reimburse the provider at the usual and customary rate or at a rate agreed to by the provider and the defined network plan.

2. Require the enrollee to pay an amount for the emergency services that is no more than the enrollee would have paid if the provider had been in the defined network plan's network.

(5) MEDICALLY NECESSARY SERVICES. If an enrollee of a defined network plan or a preferred provider plan that restricts or increases cost sharing for use of providers that are not in its network is unable to obtain medically necessary services within a reasonable time from a provider in the plan's network, the plan shall, upon the request of a provider that is in the plan's network, do all of the following:

(a) Within a reasonable time, allow referral to a provider that is not within the plan's network.

(b) Reimburse the provider that is not in the plan's network at the usual and customary rate or at a rate agreed to between the provider and the plan. The enrollee shall provide to the provider under this paragraph an assignment of benefits from the enrollee to the provider for any service, item, or supply that the provider provides to the enrollee.

(c) Require the enrollee to pay an amount for the medically necessary services that is no more than the enrollee would have paid if the provider had been in the preferred provider plan's or defined network plan's network.

(6) MEDIATION. (a) Except as provided under par. (b), an enrollee of a defined network plan or preferred provider plan shall be entitled to request mediation to resolve a claim of a provider if all of the following apply:

1. The provider is not in the network of the enrollee's defined network plan or preferred provider plan.

2. The provider is under contract to provide services at a health care facility that is in the network of the enrollee's defined network plan or preferred provider plan.

3. The enrollee is responsible for an amount, after copayments, deductibles, and coinsurance, that exceeds $500.

(b) The enrollee is not entitled to request mediation if all of the following apply:

1. The provider or health care facility provided the information under sub. (3).

2. The amount that the enrollee is responsible for, after copayments, deductibles, and coinsurance, is less than the good faith estimate provided under sub. (3) (a) 2.

(c) The defined network plan or preferred provider plan shall include in an explanation of benefits statement provided to an enrollee a notice that the enrollee may be entitled to request mediation as provided under this subsection.

(7) RULES. The commissioner may promulgate rules to establish procedures for mediation under this section.

(8) CONFLICTS. To the extent that this section conflicts with s. 609.10, 609.91, or 609.92, this section supersedes ss. 609.10, 609.91, and 609.92.

SECTION 2. Initial applicability.

(1) (a) For plans or contracts containing provisions inconsistent with this act, the act first applies to plan or contract years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in par. (b).

(b) For plans or contracts that are affected by a collective bargaining agreement containing provisions inconsistent with this act, this act first applies to plan or contract years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 3. Effective date.

(1) This act takes effect on first day of the 7th month beginning after publication.

(END)

Lunder, Erika

From: Konecke, Maria
Sent: Thursday, October 10, 2019 3:59 PM
To: Lunder, Erika
Cc: Sovey, Meghan
Subject: LRB-4389

Hi Erika,

After looking over the re-draft with Sen. Smith's office, we have a couple of questions:

1. On page 6, line 15: can this line be deleted without significant impact to the rest of the bill? This provision wasn't in our last draft, and we would like to keep it out.
2. Page 2 (analysis, paragraph 2)-"Under the bill, an enrollee may not request arbitration if the amount for which he or she is financially responsible does not exceed $500 or," –can this sentence be changed to the language from the original draft? The first draft reads as: "The enrollee is entitled to mediation (arbitration in the new draft) for a claim if the amount that the enrollee is financially responsible for, after copayments, deductibles, and coinsurance, is more than $500."

Please let me know if these changes are possible, or if you have any questions.

Thanks again for your work on this!

Best,

Maria Konecke
Office of Rep. Debra Kolste
44th Assembly District
Phone: (608) 237-9144

State of Wisconsin
2019 - 2020 LEGISLATURE

LRB-4389/P1 (P2)
EKL:ahe&cjs

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

ID: 10/16
DVE: 10/18

AN ACT *to create* 609.07 of the statutes; **relating to:** imposing disclosure and billing requirements for certain health care providers, creating an arbitration process, and granting rule-making authority.

Analysis by the Legislative Reference Bureau

This bill creates disclosure, notice, billing, and arbitration requirements for the situation in which an enrollee in a defined network or preferred provider plan ("plan") may receive services from a health care provider that is not in the plan's network.

Under the bill, a plan must annually provide to enrollees a directory of providers and a list of health care facilities that are in its network. The bill also requires that a provider who is not in the network of the enrollee's plan but is providing a service at an in-network health care facility must disclose that information to the enrollee, provide the enrollee a good faith estimate of the cost of services the enrollee may be responsible for, and inform the enrollee of the availability of arbitration to settle disputes over the cost of services. The health care facility may opt to provide the notice for the provider.

Under the bill, if an enrollee of a plan requires medically necessary services that are not available from an in-network provider within a reasonable time, then the plan must provide an opportunity for referral to an out-of-network provider. The plan must reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid had the provider been in the plan's network. If there a dispute over the reimbursement, the plan or provider may

submit the dispute using the arbitration process described below. The bill requires the enrollee to provide the out-of-network provider an assignment of benefits for any service, item, or supply provided by that provider.

Similarly, under the bill, if an enrollee of a plan receives emergency services from an out-of-network provider, then the plan must reimburse the provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid if the provider was in the plan's network. If there a dispute over the reimbursement, the plan or provider may submit the dispute using the arbitration process described below.

The bill requires the commissioner of insurance to promulgate rules to establish the arbitration process under which enrollees, plans, and out-of-network providers may submit billing disputes to an independent dispute resolution entity. Under the bill, an enrollee may not request arbitration if the amount for which he or she is financially responsible does not exceed $500 or, if the provider or health care facility complied with the disclosures requirements described above, is less than the good faith estimate provided by the provider. The plan or provider may not use the arbitration process to dispute bills for certain emergency services that do not exceed a specified amount or services for which provider fees are subject by law to monetary limitations.

Once a dispute is filed, the independent dispute resolution entity has 30 days to determine a reasonable fee for the services provided to the enrollee by the out-of-network provider. If the dispute is between the plan and provider, each party submits what it thinks is a reasonable fee for the services, and the independent dispute resolution entity must choose one of those amounts. However, if the entity finds that both sides' amounts are unreasonable or that a settlement between the parties is likely, it may direct the plan and provider to attempt a good faith negotiation for settlement and, if they reach an agreement, the entity will select that amount as its final determination. If the dispute is between the enrollee and provider, the independent dispute resolution entity determines a reasonable fee based upon factors that include whether there is a gross disparity between the fee billed by the provider and other fees charged by that provider; the provider's training and experience; and the circumstances and complexity of the particular case. The entity's determination is binding on the parties.

The bill provides that the losing party must pay the costs of the arbitration with two exceptions. First, if a settlement is reached between a plan and provider at the direction of the independent dispute resolution entity, the costs are evenly divided between the parties. Second, if the enrollee is the losing party and the commissioner determines that paying the costs would be a hardship for the enrollee, the commissioner provides for the payment of the costs.

Under the bill, an ~~employee~~ enrollee may request arbitration for a claim if the amount that the enrollee is financially responsible for, after copayments, deductibles, and coinsurance, is more than $500, unless that amount

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. 609.07 of the statutes is created to read:

609.07 Balance billing. (1) DEFINITIONS. In this section:

(a) "Assignment of benefits" means a written instrument signed by an insured or the authorized representative of an insured that assigns to a provider the insured's claim for payment, reimbursement, or benefits under a disability insurance policy as defined in s. 632.895 (1) (a).

(b) "Emergency services" means those services required to treat and stabilize an emergency medical condition in accordance with 42 USC 1395dd and services originating in a hospital emergency department, a freestanding emergency department, or a similar facility following treatment or stabilization of an emergency medical condition.

(c) "Network" means the providers that are under contract with a defined network plan or preferred provider plan to provide services to enrollees at an agreed price, for which the provider receives reimbursement in accordance with the contract.

(2) NOTICE OF NETWORK STATUS. (a) A defined network plan or preferred provider plan shall provide, no less frequently than annually, a list of health care facilities that have agreed to facilitate the usage of providers that are in the plan's network. The list shall specify the percentage of providers at those health care facilities that are not in the plan's network.

(b) A defined network plan or preferred provider plan shall provide, no less frequently than annually, a directory of all providers that are in the plan's network and are under contract with health care facilities that are in the plan's network. In the directory, the defined network plan or preferred provider plan shall specify health care facilities that do not have contracts with providers in a particular specialty.

(3) DISCLOSURES. (a) A provider that is not in a defined network plan's or preferred provider plan's network and is under contract to provide services at a health care facility that is in the plan's network shall provide, in writing, to an enrollee of the defined network plan or preferred provider plan all of the following:

1. That the enrollee may receive services from a provider that is not in the defined network plan's or preferred provider plan's network.

2. A good faith estimate of the enrollee's financial responsibility for the services provided under subd. 1.

3. That the enrollee is entitled to arbitration under circumstances described in sub. (6) (a).

(b) In lieu of the provider providing the notice under par. (a), a health care facility may provide the notice described under par. (a).

(4) EMERGENCY SERVICES. (a) If an enrollee of a preferred provider plan that restricts or increases cost sharing for use of providers that are not in its network obtains emergency services from a provider not in the plan's network, the preferred provider plan shall do all of the following:

1. Allow the enrollee to obtain services from the provider until the enrollee can be transferred to a provider that is in the preferred provider plan's network in accordance with 42 USC 1395dd.

2. Reimburse the provider at the usual and customary rate or at a rate agreed to by the provider and the preferred provider plan.

3. Require the enrollee to pay an amount for the emergency services that is no more than the enrollee would have paid if the provider had been in the preferred provider plan's network.

(b) If an enrollee of a defined network plan obtains emergency services from a provider that is not in the plan's network, the defined network plan shall do all of the following:

1. Reimburse the provider at the usual and customary rate or at a rate agreed to by the provider and the defined network plan.

2. Require the enrollee to pay an amount for the emergency services that is no more than the enrollee would have paid if the provider had been in the defined network plan's network.

(5) MEDICALLY NECESSARY SERVICES. If an enrollee of a defined network plan or a preferred provider plan that restricts or increases cost sharing for use of providers that are not in its network is unable to obtain medically necessary services within a reasonable time from a provider in the plan's network, the plan shall, upon the request of a provider that is in the plan's network, do all of the following:

(a) Within a reasonable time, allow referral to a provider that is not within the plan's network.

(b) Reimburse the provider that is not in the plan's network at the usual and customary rate or at a rate agreed to between the provider and the plan. The enrollee shall provide to the provider under this paragraph an assignment of benefits from the enrollee to the provider for any service, item, or supply that the provider provides to the enrollee.

(c) Require the enrollee to pay an amount for the medically necessary services that is no more than the enrollee would have paid if the provider had been in the preferred provider plan's or defined network plan's network.

(6) ARBITRATION. (a) *Enrollees.* 1. Except as provided under subd. 2., an enrollee of a defined network plan or preferred provider plan shall be entitled to submit a dispute of a claim of a provider to arbitration if all of the following apply:

a. The provider is not in the network of the enrollee's defined network plan or preferred provider plan.

b. The provider is under contract to provide services at a health care facility that is in the network of the enrollee's defined network plan or preferred provider plan.

c. The enrollee is responsible for an amount, after copayments, deductibles, and coinsurance, that exceeds $500.

2. The enrollee is not entitled to request arbitration if all of the following apply:

a. The provider or health care facility provided the information under sub. (3).

b. The amount that the enrollee is responsible for, after copayments, deductibles, and coinsurance, is less than the good faith estimate provided under sub. (3) (a) 2.

3. The defined network plan or preferred provider plan shall include in an explanation of benefits statement provided to an enrollee a notice that the enrollee may be entitled to request arbitration as provided under this subsection.

(b) *Plans and providers.* If there is a dispute over a payment under sub. (4) (a) 2. or (b) 1. or (5) (b), the plan or provider may submit the dispute for arbitration, except that a dispute involving any of the following may not be submitted:

1. Services for which provider fees are subject by law to schedules or other monetary limitations.

2. Emergency services billed under American Medical Association Current Procedural Terminology codes 99217 to 99220, 99224 to 99226, 99234 to 99236, 99281 to 99285, 99288, and 99291 to 99292 if the amount billed for a specific code does not exceed 120 percent of the usual and customary cost for the code and does not exceed the exemption amount. The exemption amount shall be $600 in 2020 and shall be adjusted annually by the commissioner to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor, for the 12 months ending on December 31 of the preceding year, except that the exemption amount may not exceed $1,200.

(c) *Establishment.* The commissioner shall establish an arbitration process to resolve disputes that are submitted under par. (a) or (b). The commissioner shall certify at least one independent dispute resolution entity to conduct the arbitration process. In order to obtain and maintain certification, an independent dispute resolution entity shall use licensed providers who are in active practice in the same or similar specialty as the provider providing the service subject to dispute and who, to the extent practicable, are licensed in this state. The commissioner shall, by rule, establish a process for submitting a dispute for arbitration and standards for the arbitration process, including a process for certifying an independent dispute resolution entity and revoking the certification when appropriate.

(d) *Arbitration process.* When a party submits a dispute for arbitration under par. (a) or (b), the independent dispute resolution entity shall determine the amount of a reasonable fee for the services provided by the provider to the enrollee according to the conditions of this paragraph. The independent dispute resolution entity shall

provide the determination, in writing, to the parties and the commissioner no later than 30 days after the dispute is submitted to the entity.

1. For a dispute submitted under par. (a), the independent dispute resolution entity shall determine if the fee charged by the provider to the enrollee is reasonable based on the factors in par. (e). If the entity determines the fee is reasonable, the entity shall select that amount as its determination. If the entity determines the fee is not reasonable, the entity shall determine a reasonable fee based on the factors in par. (e).

2. For a dispute submitted under par. (b), the plan and provider shall each submit an amount to the independent dispute resolution entity, and the entity shall select one of the amounts based on the factors in par. (e); except that, if the entity determines that the amounts submitted by the parties are unreasonable or that a settlement between the parties is reasonably likely, the entity may direct the parties to attempt a good faith negotiation for settlement. If the plan and provider agree to an amount, the independent dispute resolution entity shall select that amount as its determination.

(e) *Reasonable fee criteria.* The independent dispute resolution entity shall consider all of the following factors when determining a reasonable fee under par. (d):

1. The provider's usual charge for comparable services rendered to patients covered by plans for which the provider is not in network.

2. Whether there is a gross disparity between the fee billed by the provider as compared to fees paid to that provider for the same services rendered to other patients covered by plans for which the provider is not in network and, in the case of a dispute submitted under par. (b), fees paid by the plan to reimburse similarly qualified providers who are not in the plan's network.

3. The level of training, education, and experience of the provider.

4. The circumstances and complexity of the particular case, including time and place of the service.

5. Individual characteristics of the enrollee.

6. The usual and customary cost of the service.

7. Any factors identified by the commissioner by rule.

8. Any factors the entity determines are relevant based on the specific facts and circumstances of the dispute.

(f) *Binding effect.* The determination of the independent dispute resolution entity shall be binding on the parties to the dispute and shall be admissible in a court proceeding between them and in any administrative proceeding between this state and the provider.

(g) *Costs.* For disputes submitted under par. (a), the costs for the arbitration process shall be paid by the enrollee if the independent dispute resolution entity determines that the fee charged by the provider to the enrollee is reasonable and by the provider if the entity determines that the fee is not reasonable; except that the commissioner may waive or reduce the costs charged to the enrollee if requiring full payment would impose a hardship on the enrollee. The commissioner shall, by rule, specify the factors to be considered in making the determination of hardship and provide for the payment of costs in cases of hardship. For disputes submitted under par. (b), the costs for the arbitration process shall be paid by the party whose amount is not selected by the independent dispute resolution entity or, if a settlement is reached, by both parties in equal amounts.

(7) CONFLICTS. To the extent that this section conflicts with s. 609.10, 609.91, or 609.92, this section supersedes ss. 609.10, 609.91, and 609.92.

SECTION 2. Initial applicability.

(1) (a) For plans or contracts containing provisions inconsistent with this act, the act first applies to plan or contract years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in par. (b).

(b) For plans or contracts that are affected by a collective bargaining agreement containing provisions inconsistent with this act, this act first applies to plan or contract years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 3. Effective date.

(1) This act takes effect on first day of the 7th month beginning after publication.

(END)

Lunder, Erika

From: Konecke, Maria
Sent: Friday, November 15, 2019 2:39 PM
To: Lunder, Erika
Subject: OCI Language Change Suggestions

Hi Erika,

Here are the suggestions OCI sent me:

Thank you for the call back to talk through the response to your questions on drafting for page 9. To follow up:

- Our attorneys noted that the arbitration cost might be prohibitive for anyone seeking to challenge a cost assessed by a provider (even if there is an option to reduce it due to hardship/undue burden) and that it might be best to outline a mechanism whereby OCI can pay for the arbitration costs through a fee or assessment on the industry side.
- They also mentioned that you might be able to outline a fee to the enrollee if a cost is determined to be fair to exceed no more than $100 (just as an example). With this, however, you could still allow OCI to determine if that $100 should be waived due to hardship.

cost

? - all ins.

Maria Konecke
Office of Rep. Debra Kolste
44th Assembly District
Phone: (608) 237-9144

-do both: $100 cap & impose fee for unpaid enrollee arb. costs on insurers

also, change In. App. sec. 1 to "second year" after takes effect

State of Wisconsin
2019 - 2020 LEGISLATURE

LRB-4389/P2 (P3)
EKL:ahe&cjs
stays

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

IN 11/18 INSERT
DUE: 11/18

SA
SC

AN ACT *to create* 609.07 of the statutes; **relating to:** imposing disclosure and billing requirements for certain health care providers, creating an arbitration process, and granting rule-making authority.

Analysis by the Legislative Reference Bureau

This bill creates disclosure, notice, billing, and arbitration requirements for the situation in which an enrollee in a defined network or preferred provider plan ("plan") may receive services from a health care provider that is not in the plan's network.

Under the bill, a plan must annually provide to enrollees a directory of providers and a list of health care facilities that are in its network. The bill also requires that a provider who is not in the network of the enrollee's plan but is providing a service at an in-network health care facility must disclose that information to the enrollee, provide the enrollee a good faith estimate of the cost of services the enrollee may be responsible for, and inform the enrollee of the availability of arbitration to settle disputes over the cost of services. The health care facility may opt to provide the notice for the provider.

Under the bill, if an enrollee of a plan requires medically necessary services that are not available from an in-network provider within a reasonable time, then the plan must provide an opportunity for referral to an out-of-network provider. The plan must reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid had the provider been in the plan's network. If there a dispute over the reimbursement, the plan or provider may

submit the dispute using the arbitration process described below. The bill requires the enrollee to provide the out-of-network provider an assignment of benefits for any service, item, or supply provided by that provider.

Similarly, under the bill, if an enrollee of a plan receives emergency services from an out-of-network provider, then the plan must reimburse the provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid if the provider was in the plan's network. If there a dispute over the reimbursement, the plan or provider may submit the dispute using the arbitration process described below.

The bill requires the commissioner of insurance to promulgate rules to establish the arbitration process under which enrollees, plans, and out-of-network providers may submit billing disputes to an independent dispute resolution entity. Under the bill, an enrollee may request arbitration for a claim if the amount that the enrollee is financially responsible for, after copayments, deductibles, and coinsurance, is more than $500, unless that amount is less than the good faith estimate provided by the provider. The plan or provider may not use the arbitration process to dispute bills for certain emergency services that do not exceed a specified amount or services for which provider fees are subject by law to monetary limitations.

Once a dispute is filed, the independent dispute resolution entity has 30 days to determine a reasonable fee for the services provided to the enrollee by the out-of-network provider. If the dispute is between the plan and provider, each party submits what it thinks is a reasonable fee for the services, and the independent dispute resolution entity must choose one of those amounts. However, if the entity finds that both sides' amounts are unreasonable or that a settlement between the parties is likely, it may direct the plan and provider to attempt a good faith negotiation for settlement and, if they reach an agreement, the entity will select that amount as its final determination. If the dispute is between the enrollee and provider, the independent dispute resolution entity determines a reasonable fee based upon factors that include whether there is a gross disparity between the fee billed by the provider and other fees charged by that provider; the provider's training and experience; and the circumstances and complexity of the particular case. The entity's determination is binding on the parties.

The bill provides that the losing party must pay the costs of the arbitration with two exceptions. First, if a settlement is reached between a plan and provider at the direction of the independent dispute resolution entity, the costs are evenly divided between the parties. Second, if the enrollee is the losing party and the commissioner determines that paying the costs would be a hardship for the enrollee, the commissioner provides for the payment of the costs.

INS-A

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:

INS 3-1 →

SECTION 1. 609.07 of the statutes is created to read:

609.07 Balance billing. (1) DEFINITIONS. In this section:

(a) "Assignment of benefits" means a written instrument signed by an insured or the authorized representative of an insured that assigns to a provider the insured's claim for payment, reimbursement, or benefits under a disability insurance policy as defined in s. 632.895 (1) (a).

(b) "Emergency services" means those services required to treat and stabilize an emergency medical condition in accordance with 42 USC 1395dd and services originating in a hospital emergency department, a freestanding emergency department, or a similar facility following treatment or stabilization of an emergency medical condition.

(c) "Network" means the providers that are under contract with a defined network plan or preferred provider plan to provide services to enrollees at an agreed price, for which the provider receives reimbursement in accordance with the contract.

(2) NOTICE OF NETWORK STATUS. (a) A defined network plan or preferred provider plan shall provide, no less frequently than annually, a list of health care facilities that have agreed to facilitate the usage of providers that are in the plan's network. The list shall specify the percentage of providers at those health care facilities that are not in the plan's network.

(b) A defined network plan or preferred provider plan shall provide, no less frequently than annually, a directory of all providers that are in the plan's network and are under contract with health care facilities that are in the plan's network. In the directory, the defined network plan or preferred provider plan shall specify health care facilities that do not have contracts with providers in a particular specialty.

(3) DISCLOSURES. (a) A provider that is not in a defined network plan's or preferred provider plan's network and is under contract to provide services at a health care facility that is in the plan's network shall provide, in writing, to an enrollee of the defined network plan or preferred provider plan all of the following:

1. That the enrollee may receive services from a provider that is not in the defined network plan's or preferred provider plan's network.

2. A good faith estimate of the enrollee's financial responsibility for the services provided under subd. 1.

3. That the enrollee is entitled to arbitration under circumstances described in sub. (6) (a).

(b) In lieu of the provider providing the notice under par. (a), a health care facility may provide the notice described under par. (a).

(4) EMERGENCY SERVICES. (a) If an enrollee of a preferred provider plan that restricts or increases cost sharing for use of providers that are not in its network obtains emergency services from a provider not in the plan's network, the preferred provider plan shall do all of the following:

1. Allow the enrollee to obtain services from the provider until the enrollee can be transferred to a provider that is in the preferred provider plan's network in accordance with 42 USC 1395dd.

2. Reimburse the provider at the usual and customary rate or at a rate agreed to by the provider and the preferred provider plan.

3. Require the enrollee to pay an amount for the emergency services that is no more than the enrollee would have paid if the provider had been in the preferred provider plan's network.

(b) If an enrollee of a defined network plan obtains emergency services from a provider that is not in the plan's network, the defined network plan shall do all of the following:

1. Reimburse the provider at the usual and customary rate or at a rate agreed to by the provider and the defined network plan.

2. Require the enrollee to pay an amount for the emergency services that is no more than the enrollee would have paid if the provider had been in the defined network plan's network.

(5) MEDICALLY NECESSARY SERVICES. If an enrollee of a defined network plan or a preferred provider plan that restricts or increases cost sharing for use of providers that are not in its network is unable to obtain medically necessary services within a reasonable time from a provider in the plan's network, the plan shall, upon the request of a provider that is in the plan's network, do all of the following:

(a) Within a reasonable time, allow referral to a provider that is not within the plan's network.

(b) Reimburse the provider that is not in the plan's network at the usual and customary rate or at a rate agreed to between the provider and the plan. The enrollee shall provide to the provider under this paragraph an assignment of benefits from the enrollee to the provider for any service, item, or supply that the provider provides to the enrollee.

(c) Require the enrollee to pay an amount for the medically necessary services that is no more than the enrollee would have paid if the provider had been in the preferred provider plan's or defined network plan's network.

(6) ARBITRATION. (a) *Enrollees.* 1. Except as provided under subd. 2., an enrollee of a defined network plan or preferred provider plan shall be entitled to submit a dispute of a claim of a provider to arbitration if all of the following apply:

a. The provider is not in the network of the enrollee's defined network plan or preferred provider plan.

b. The provider is under contract to provide services at a health care facility that is in the network of the enrollee's defined network plan or preferred provider plan.

c. The enrollee is responsible for an amount, after copayments, deductibles, and coinsurance, that exceeds $500.

2. The enrollee is not entitled to request arbitration if the amount that the enrollee is responsible for, after copayments, deductibles, and coinsurance, is less than the good faith estimate provided under sub. (3) (a) 2.

3. The defined network plan or preferred provider plan shall include in an explanation of benefits statement provided to an enrollee a notice that the enrollee may be entitled to request arbitration as provided under this subsection.

(b) *Plans and providers.* If there is a dispute over a payment under sub. (4) (a) 2. or (b) 1. or (5) (b), the plan or provider may submit the dispute for arbitration, except that a dispute involving any of the following may not be submitted:

1. Services for which provider fees are subject by law to schedules or other monetary limitations.

2. Emergency services billed under American Medical Association Current Procedural Terminology codes 99217 to 99220, 99224 to 99226, 99234 to 99236, 99281 to 99285, 99288, and 99291 to 99292 if the amount billed for a specific code does not exceed 120 percent of the usual and customary cost for the code and does not exceed the exemption amount. The exemption amount shall be $600 in 2020 and shall be adjusted annually by the commissioner to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor, for the 12 months ending on December 31 of the preceding year, except that the exemption amount may not exceed $1,200.

(c) *Establishment.* The commissioner shall establish an arbitration process to resolve disputes that are submitted under par. (a) or (b). The commissioner shall certify at least one independent dispute resolution entity to conduct the arbitration process. In order to obtain and maintain certification, an independent dispute resolution entity shall use licensed providers who are in active practice in the same or similar specialty as the provider providing the service subject to dispute and who, to the extent practicable, are licensed in this state. The commissioner shall, by rule, establish a process for submitting a dispute for arbitration and standards for the arbitration process, including a process for certifying an independent dispute resolution entity and revoking the certification when appropriate.

(d) *Arbitration process.* When a party submits a dispute for arbitration under par. (a) or (b), the independent dispute resolution entity shall determine the amount of a reasonable fee for the services provided by the provider to the enrollee according to the conditions of this paragraph. The independent dispute resolution entity shall provide the determination, in writing, to the parties and the commissioner no later than 30 days after the dispute is submitted to the entity.

1. For a dispute submitted under par. (a), the independent dispute resolution entity shall determine if the fee charged by the provider to the enrollee is reasonable based on the factors in par. (e). If the entity determines the fee is reasonable, the entity shall select that amount as its determination. If the entity determines the fee is not reasonable, the entity shall determine a reasonable fee based on the factors in par. (e).

2. For a dispute submitted under par. (b), the plan and provider shall each submit an amount to the independent dispute resolution entity, and the entity shall select one of the amounts based on the factors in par. (e); except that, if the entity determines that the amounts submitted by the parties are unreasonable or that a settlement between the parties is reasonably likely, the entity may direct the parties to attempt a good faith negotiation for settlement. If the plan and provider agree to an amount, the independent dispute resolution entity shall select that amount as its determination.

(e) *Reasonable fee criteria.* The independent dispute resolution entity shall consider all of the following factors when determining a reasonable fee under par. (d):

1. The provider's usual charge for comparable services rendered to patients covered by plans for which the provider is not in network.

2. Whether there is a gross disparity between the fee billed by the provider as compared to fees paid to that provider for the same services rendered to other patients covered by plans for which the provider is not in network and, in the case of a dispute submitted under par. (b), fees paid by the plan to reimburse similarly qualified providers who are not in the plan's network.

3. The level of training, education, and experience of the provider.

4. The circumstances and complexity of the particular case, including time and place of the service.

5. Individual characteristics of the enrollee.

6. The usual and customary cost of the service.

7. Any factors identified by the commissioner by rule.

8. Any factors the entity determines are relevant based on the specific facts and circumstances of the dispute.

(f) *Binding effect.* The determination of the independent dispute resolution entity shall be binding on the parties to the dispute and shall be admissible in a court proceeding between them and in any administrative proceeding between this state and the provider.

(g) *Costs.* For disputes submitted under par. (a), the costs for the arbitration process shall be paid by the enrollee if the independent dispute resolution entity determines that the fee charged by the provider to the enrollee is reasonable and by the provider if the entity determines that the fee is not reasonable; except that the commissioner may waive or reduce the costs charged to the enrollee if requiring full payment would impose a hardship on the enrollee. The commissioner shall, by rule, specify the factors to be considered in making the determination of hardship and provide for the payment of costs in cases of hardship. For disputes submitted under par. (b), the costs for the arbitration process shall be paid by the party whose amount is not selected by the independent dispute resolution entity or, if a settlement is reached, by both parties in equal amounts.

(7) CONFLICTS. To the extent that this section conflicts with s. 609.10, 609.91, or 609.92, this section supersedes ss. 609.10, 609.91, and 609.92.

SECTION 2. Initial applicability.

(1) (a) For plans or contracts containing provisions inconsistent with this act, the act first applies to plan or contract years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in par. (b).

(b) For plans or contracts that are affected by a collective bargaining agreement containing provisions inconsistent with this act, this act first applies to plan or contract years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 3. Effective date.

(1) This act takes effect on first day of the 7th month beginning after publication.

(END)

INS-A

Second, if the enrollee is the losing party, the maximum amount the enrollee may be charged is $100 and the commissioner may waive or reduce the charge if requiring full payment would impose a hardship on the enrollee. The bill imposes an annual fee on insurers that is used to pay the arbitration costs that are otherwise unpaid by enrollees. The fee is established by the commissioner.

INS 3-1

SECTION 1. 601.31 (1) (b) 1. of the statutes is amended to read:

601.31 **(1)** (b) 1. Domestic and nondomestic insurers, $400 plus the amount determined under s. 609.07 (6) (g) 1.

History: 1971 c. 40 s. 93; 1971 c. 125, 260, 307; 1975 c. 223, 371, 373, 374, 421; 1979 c. 102 ss. 63 to 65, 237; 1979 c. 261, 355; 1981 c. 20 ss. 1739 to 1748, 2202 (26) (a); 1981 c. 38, 314; 1983 a. 358; 1985 a. 29; 1987 a. 27, 166; 1989 a. 31; 1991 a. 39; 1993 a. 112; 1995 a. 27, 371, 396; 1999 a. 9, 155; 2003 a. 261, 302; 2007 a. 169; 2009 a. 28, 342, 344; 2011 a. 209, 226; 2013 a. 20, 271; 2017 a. 59.

SECTION 2. 601.31 (1) (c) 1. of the statutes is amended to read:

601.31 **(1)** (c) 1. Domestic and nondomestic insurers, $100 plus the amount determined under s. 609.07 (6) (g) 1.

History: 1971 c. 40 s. 93; 1971 c. 125, 260, 307; 1975 c. 223, 371, 373, 374, 421; 1979 c. 102 ss. 63 to 65, 237; 1979 c. 261, 355; 1981 c. 20 ss. 1739 to 1748, 2202 (26) (a); 1981 c. 38, 314; 1983 a. 358; 1985 a. 29; 1987 a. 27, 166; 1989 a. 31; 1991 a. 39; 1993 a. 112; 1995 a. 27, 371, 396; 1999 a. 9, 155; 2003 a. 261, 302; 2007 a. 169; 2009 a. 28, 342, 344; 2011 a. 209, 226; 2013 a. 20, 271; 2017 a. 59.

INS 9-19

The commissioner shall pay the amount of arbitration costs that are otherwise unpaid by enrollees under this subdivision from the appropriation under s. 20.145 (1) (g) and shall increase the fees required by s. 601.31 (1) (b) 1. and (c) 1. to cover the unpaid arbitration costs.

by rules

Lunder, Erika

From: Konecke, Maria
Sent: Friday, November 22, 2019 8:12 AM
To: Lunder, Erika
Cc: Sovey, Meghan
Subject: FW: Follow up you requested

Hi Erika,

Below is OCI's message regarding their suggested change to the draft. I'm around all day if you want to give me a call about it.

call w/ Maria
- delete fee language
- OCI determines how to cover

Thanks,

Maria Konecke
Office of Rep. Debra Kolste
44th Assembly District
Phone: (608) 237-9144

From: Hwang, Olivia C - OCI <olivia.hwang@wisconsin.gov>
Sent: Thursday, November 21, 2019 5:15 PM
To: Konecke, Maria <Maria.Konecke@legis.wisconsin.gov>
Cc: Stegall, Jennifer - OCI <Jennifer.Stegall@wisconsin.gov>
Subject: Follow up you requested

Maria,

After Jen and I spoke with you, you called back and asked if we could be more specific about the changes for the drafter.

The section that Jen referenced changing was this:

Page 9, Line 25 – Page 10, Line 3
The commissioner shall pay the amount of arbitration costs that are otherwise unpaid by enrollees under this subdivision from the appropriation under s. 20.145 (1) (g) and shall, by rule, increase the fees required by s. 601.31 (1) (b) 1. and (c) 1. to cover the unpaid arbitration costs.

Jen, please correct me if I am wrong, but I believe what we're saying is rather than specifically outlining that we'll increase fees required by *s. 601.31 (1) (b) 1. and (c) 1.*, that we believe it would be best if OCI were given rulemaking authority to determine a mechanism to cover unpaid arbitration costs.

Please let me know if that provides the clarity you requested.

Thanks,
Olivia

Olivia Hwang
Director of Public Affairs

WI Office of the Commissioner of Insurance
608.209.6309
olivia.hwang@wisconsin.gov

Wisconsin Office of the
Commissioner of Insurance

State of Wisconsin
2019 - 2020 LEGISLATURE

LRB-4389/P3
EKL:ahe&cjs

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ***to amend*** 601.31 (1) (b) 1. and 601.31 (1) (c) 1.; and ***to create*** 609.07 of the statutes; **relating to:** imposing disclosure and billing requirements for certain health care providers, creating an arbitration process, and granting rule-making authority.

Analysis by the Legislative Reference Bureau

This bill creates disclosure, notice, billing, and arbitration requirements for the situation in which an enrollee in a defined network or preferred provider plan ("plan") may receive services from a health care provider that is not in the plan's network.

Under the bill, a plan must annually provide to enrollees a directory of providers and a list of health care facilities that are in its network. The bill also requires that a provider who is not in the network of the enrollee's plan but is providing a service at an in-network health care facility must disclose that information to the enrollee, provide the enrollee a good faith estimate of the cost of services the enrollee may be responsible for, and inform the enrollee of the availability of arbitration to settle disputes over the cost of services. The health care facility may opt to provide the notice for the provider.

Under the bill, if an enrollee of a plan requires medically necessary services that are not available from an in-network provider within a reasonable time, then the plan must provide an opportunity for referral to an out-of-network provider. The plan must reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the

enrollee to pay more than the enrollee would have paid had the provider been in the plan's network. If there a dispute over the reimbursement, the plan or provider may submit the dispute using the arbitration process described below. The bill requires the enrollee to provide the out-of-network provider an assignment of benefits for any service, item, or supply provided by that provider.

Similarly, under the bill, if an enrollee of a plan receives emergency services from an out-of-network provider, then the plan must reimburse the provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid if the provider was in the plan's network. If there a dispute over the reimbursement, the plan or provider may submit the dispute using the arbitration process described below.

The bill requires the commissioner of insurance to promulgate rules to establish the arbitration process under which enrollees, plans, and out-of-network providers may submit billing disputes to an independent dispute resolution entity. Under the bill, an enrollee may request arbitration for a claim if the amount that the enrollee is financially responsible for, after copayments, deductibles, and coinsurance, is more than $500, unless that amount is less than the good faith estimate provided by the provider. The plan or provider may not use the arbitration process to dispute bills for certain emergency services that do not exceed a specified amount or services for which provider fees are subject by law to monetary limitations.

Once a dispute is filed, the independent dispute resolution entity has 30 days to determine a reasonable fee for the services provided to the enrollee by the out-of-network provider. If the dispute is between the plan and provider, each party submits what it thinks is a reasonable fee for the services, and the independent dispute resolution entity must choose one of those amounts. However, if the entity finds that both sides' amounts are unreasonable or that a settlement between the parties is likely, it may direct the plan and provider to attempt a good faith negotiation for settlement and, if they reach an agreement, the entity will select that amount as its final determination. If the dispute is between the enrollee and provider, the independent dispute resolution entity determines a reasonable fee based upon factors that include whether there is a gross disparity between the fee billed by the provider and other fees charged by that provider; the provider's training and experience; and the circumstances and complexity of the particular case. The entity's determination is binding on the parties.

The bill provides that the losing party must pay the costs of the arbitration with two exceptions. First, if a settlement is reached between a plan and provider at the direction of the independent dispute resolution entity, the costs are evenly divided between the parties. Second, if the enrollee is the losing party, the maximum amount the enrollee may be charged is $100 and the commissioner may waive or reduce the charge if requiring full payment would impose a hardship on the enrollee. The bill imposes an annual fee on insurers that is used to pay the arbitration costs that are otherwise unpaid by enrollees. The fee is established by the commissioner

requires the commissioner to determine and establish a mechanism to cover

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. 601.31 (1) (b) 1. of the statutes is amended to read:

601.31 **(1)** (b) 1. Domestic and nondomestic insurers, $400 plus the amount determined under s. 609.07 (6) (g) 1.

SECTION 2. 601.31 (1) (c) 1. of the statutes is amended to read:

601.31 **(1)** (c) 1. Domestic and nondomestic insurers, $100 plus the amount determined under s. 609.07 (6) (g) 1.

SECTION 3. 609.07 of the statutes is created to read:

609.07 Balance billing. (1) DEFINITIONS. In this section:

(a) "Assignment of benefits" means a written instrument signed by an insured or the authorized representative of an insured that assigns to a provider the insured's claim for payment, reimbursement, or benefits under a disability insurance policy as defined in s. 632.895 (1) (a).

(b) "Emergency services" means those services required to treat and stabilize an emergency medical condition in accordance with 42 USC 1395dd and services originating in a hospital emergency department, a freestanding emergency department, or a similar facility following treatment or stabilization of an emergency medical condition.

(c) "Network" means the providers that are under contract with a defined network plan or preferred provider plan to provide services to enrollees at an agreed price, for which the provider receives reimbursement in accordance with the contract.

(2) NOTICE OF NETWORK STATUS. (a) A defined network plan or preferred provider plan shall provide, no less frequently than annually, a list of health care facilities that have agreed to facilitate the usage of providers that are in the plan's network. The list shall specify the percentage of providers at those health care facilities that are not in the plan's network.

(b) A defined network plan or preferred provider plan shall provide, no less frequently than annually, a directory of all providers that are in the plan's network and are under contract with health care facilities that are in the plan's network. In the directory, the defined network plan or preferred provider plan shall specify health care facilities that do not have contracts with providers in a particular specialty.

(3) DISCLOSURES. (a) A provider that is not in a defined network plan's or preferred provider plan's network and is under contract to provide services at a health care facility that is in the plan's network shall provide, in writing, to an enrollee of the defined network plan or preferred provider plan all of the following:

1. That the enrollee may receive services from a provider that is not in the defined network plan's or preferred provider plan's network.

2. A good faith estimate of the enrollee's financial responsibility for the services provided under subd. 1.

3. That the enrollee is entitled to arbitration under circumstances described in sub. (6) (a).

(b) In lieu of the provider providing the notice under par. (a), a health care facility may provide the notice described under par. (a).

(4) EMERGENCY SERVICES. (a) If an enrollee of a preferred provider plan that restricts or increases cost sharing for use of providers that are not in its network

obtains emergency services from a provider not in the plan's network, the preferred provider plan shall do all of the following:

1. Allow the enrollee to obtain services from the provider until the enrollee can be transferred to a provider that is in the preferred provider plan's network in accordance with 42 USC 1395dd.

2. Reimburse the provider at the usual and customary rate or at a rate agreed to by the provider and the preferred provider plan.

3. Require the enrollee to pay an amount for the emergency services that is no more than the enrollee would have paid if the provider had been in the preferred provider plan's network.

(b) If an enrollee of a defined network plan obtains emergency services from a provider that is not in the plan's network, the defined network plan shall do all of the following:

1. Reimburse the provider at the usual and customary rate or at a rate agreed to by the provider and the defined network plan.

2. Require the enrollee to pay an amount for the emergency services that is no more than the enrollee would have paid if the provider had been in the defined network plan's network.

(5) MEDICALLY NECESSARY SERVICES. If an enrollee of a defined network plan or a preferred provider plan that restricts or increases cost sharing for use of providers that are not in its network is unable to obtain medically necessary services within a reasonable time from a provider in the plan's network, the plan shall, upon the request of a provider that is in the plan's network, do all of the following:

(a) Within a reasonable time, allow referral to a provider that is not within the plan's network.

(b) Reimburse the provider that is not in the plan's network at the usual and customary rate or at a rate agreed to between the provider and the plan. The enrollee shall provide to the provider under this paragraph an assignment of benefits from the enrollee to the provider for any service, item, or supply that the provider provides to the enrollee.

(c) Require the enrollee to pay an amount for the medically necessary services that is no more than the enrollee would have paid if the provider had been in the preferred provider plan's or defined network plan's network.

(6) ARBITRATION. (a) *Enrollees.* 1. Except as provided under subd. 2., an enrollee of a defined network plan or preferred provider plan shall be entitled to submit a dispute of a claim of a provider to arbitration if all of the following apply:

a. The provider is not in the network of the enrollee's defined network plan or preferred provider plan.

b. The provider is under contract to provide services at a health care facility that is in the network of the enrollee's defined network plan or preferred provider plan.

c. The enrollee is responsible for an amount, after copayments, deductibles, and coinsurance, that exceeds $500.

2. The enrollee is not entitled to request arbitration if the amount that the enrollee is responsible for, after copayments, deductibles, and coinsurance, is less than the good faith estimate provided under sub. (3) (a) 2.

3. The defined network plan or preferred provider plan shall include in an explanation of benefits statement provided to an enrollee a notice that the enrollee may be entitled to request arbitration as provided under this subsection.

(b) *Plans and providers.* If there is a dispute over a payment under sub. (4) (a) 2. or (b) 1. or (5) (b), the plan or provider may submit the dispute for arbitration, except that a dispute involving any of the following may not be submitted:

1. Services for which provider fees are subject by law to schedules or other monetary limitations.

2. Emergency services billed under American Medical Association Current Procedural Terminology codes 99217 to 99220, 99224 to 99226, 99234 to 99236, 99281 to 99285, 99288, and 99291 to 99292 if the amount billed for a specific code does not exceed 120 percent of the usual and customary cost for the code and does not exceed the exemption amount. The exemption amount shall be $600 in 2020 and shall be adjusted annually by the commissioner to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor, for the 12 months ending on December 31 of the preceding year, except that the exemption amount may not exceed $1,200.

(c) *Establishment.* The commissioner shall establish an arbitration process to resolve disputes that are submitted under par. (a) or (b). The commissioner shall certify at least one independent dispute resolution entity to conduct the arbitration process. In order to obtain and maintain certification, an independent dispute resolution entity shall use licensed providers who are in active practice in the same or similar specialty as the provider providing the service subject to dispute and who, to the extent practicable, are licensed in this state. The commissioner shall, by rule, establish a process for submitting a dispute for arbitration and standards for the arbitration process, including a process for certifying an independent dispute resolution entity and revoking the certification when appropriate.

(d) *Arbitration process.* When a party submits a dispute for arbitration under par. (a) or (b), the independent dispute resolution entity shall determine the amount of a reasonable fee for the services provided by the provider to the enrollee according to the conditions of this paragraph. The independent dispute resolution entity shall provide the determination, in writing, to the parties and the commissioner no later than 30 days after the dispute is submitted to the entity.

1. For a dispute submitted under par. (a), the independent dispute resolution entity shall determine if the fee charged by the provider to the enrollee is reasonable based on the factors in par. (e). If the entity determines the fee is reasonable, the entity shall select that amount as its determination. If the entity determines the fee is not reasonable, the entity shall determine a reasonable fee based on the factors in par. (e).

2. For a dispute submitted under par. (b), the plan and provider shall each submit an amount to the independent dispute resolution entity, and the entity shall select one of the amounts based on the factors in par. (e); except that, if the entity determines that the amounts submitted by the parties are unreasonable or that a settlement between the parties is reasonably likely, the entity may direct the parties to attempt a good faith negotiation for settlement. If the plan and provider agree to an amount, the independent dispute resolution entity shall select that amount as its determination.

(e) *Reasonable fee criteria.* The independent dispute resolution entity shall consider all of the following factors when determining a reasonable fee under par. (d):

1. The provider's usual charge for comparable services rendered to patients covered by plans for which the provider is not in network.

2. Whether there is a gross disparity between the fee billed by the provider as compared to fees paid to that provider for the same services rendered to other patients covered by plans for which the provider is not in network and, in the case of a dispute submitted under par. (b), fees paid by the plan to reimburse similarly qualified providers who are not in the plan's network.

3. The level of training, education, and experience of the provider.

4. The circumstances and complexity of the particular case, including time and place of the service.

5. Individual characteristics of the enrollee.

6. The usual and customary cost of the service.

7. Any factors identified by the commissioner by rule.

8. Any factors the entity determines are relevant based on the specific facts and circumstances of the dispute.

(f) *Binding effect.* The determination of the independent dispute resolution entity shall be binding on the parties to the dispute and shall be admissible in a court proceeding between them and in any administrative proceeding between this state and the provider.

(g) *Costs.* 1. For disputes submitted under par. (a), the costs for the arbitration process shall be paid by the enrollee if the independent dispute resolution entity determines that the fee charged by the provider to the enrollee is reasonable and by the provider if the entity determines that the fee is not reasonable; except that the costs charged to an enrollee may not exceed $100. The commissioner may waive or reduce the costs charged to the enrollee if requiring full payment would impose a hardship on the enrollee. The commissioner shall, by rule, specify the factors to be considered in making the determination of hardship. The commissioner shall pay

and determine and establish a mechanism to cover the amount of arbitration costs that are otherwise unpaid by enrollees under this subdivision from the appropriation under s. 20.145 (1) (g) and shall, by rule, increase the fees required by s. 601.31 (1) (b) 1. and (c) 1. to cover the unpaid arbitration costs.

2. For disputes submitted under par. (b), the costs for the arbitration process shall be paid by the party whose amount is not selected by the independent dispute resolution entity or, if a settlement is reached, by both parties in equal amounts.

(7) CONFLICTS. To the extent that this section conflicts with s. 609.10, 609.91, or 609.92, this section supersedes ss. 609.10, 609.91, and 609.92.

SECTION 4. Initial applicability.

(1) (a) For plans or contracts containing provisions inconsistent with this act, the act first applies to plan or contract years beginning on January 1 of the 2nd year following the year in which this paragraph takes effect, except as provided in par. (b).

(b) For plans or contracts that are affected by a collective bargaining agreement containing provisions inconsistent with this act, this act first applies to plan or contract years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 5. Effective date.

(1) This act takes effect on first day of the 7th month beginning after publication.

(END)

2/12 Maria - 4389

- immediate version

- no jacket

State of Wisconsin
2019 - 2020 LEGISLATURE

(1)

LRB-4389/P4
EKL:ahe&cjs

No change

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ***to create*** 609.07 of the statutes; **relating to:** imposing disclosure and billing requirements for certain health care providers, creating an arbitration process, and granting rule-making authority.

Analysis by the Legislative Reference Bureau

This bill creates disclosure, notice, billing, and arbitration requirements for the situation in which an enrollee in a defined network or preferred provider plan ("plan") may receive services from a health care provider that is not in the plan's network.

Under the bill, a plan must annually provide to enrollees a directory of providers and a list of health care facilities that are in its network. The bill also requires that a provider who is not in the network of the enrollee's plan but is providing a service at an in-network health care facility must disclose that information to the enrollee, provide the enrollee a good faith estimate of the cost of services the enrollee may be responsible for, and inform the enrollee of the availability of arbitration to settle disputes over the cost of services. The health care facility may opt to provide the notice for the provider.

Under the bill, if an enrollee of a plan requires medically necessary services that are not available from an in-network provider within a reasonable time, then the plan must provide an opportunity for referral to an out-of-network provider. The plan must reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to between the provider and the plan and may not require the enrollee to pay more than the enrollee would have paid had the provider been in the plan's network. If there a dispute over the reimbursement, the plan or provider may

(7) CONFLICTS. To the extent that this section conflicts with s. 609.10, 609.91, or 609.92, this section supersedes ss. 609.10, 609.91, and 609.92.

SECTION 2. Initial applicability.

(1) (a) For plans or contracts containing provisions inconsistent with this act, the act first applies to plan or contract years beginning on January 1 of the 2nd year following the year in which this paragraph takes effect, except as provided in par. (b).

(b) For plans or contracts that are affected by a collective bargaining agreement containing provisions inconsistent with this act, this act first applies to plan or contract years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

SECTION 3. Effective date.

(1) This act takes effect on first day of the 7th month beginning after publication.

(END)

Walker, Dan

From: Konecke, Maria
Sent: Wednesday, February 12, 2020 1:41 PM
To: LRB.Legal
Subject: Draft Review: LRB -4389/1

Please Jacket LRB -4389/1 for the ASSEMBLY.