Wisconsin Office of the
COMMISSIONER
OF INSURANCE

2023 AB 784 (LRB-2611/1)

Tony Evers, Governor of Wisconsin
Nathan Houdek, Commissioner of Insurance

December 13, 2023

Mr. Richard Champagne
Acting Senate Chief Clerk
State Capitol
P.O. Box 7882
Madison, WI 53707

Mr. Ted Blazel
Assembly Chief Clerk
17 West Main Street
Room 401
Madison, WI 53703

Re: Social and Financial Impact Report—2023 Senate Bill 743 & Assembly Bill 784—relating to insurance coverage and balance billing for certain health care services.

Dear Acting Chief Clerk Champagne and Chief Clerk Blazel:

Pursuant to Wis. Stat. § 601.423, the Office of the Commissioner of Insurance (OCI) is submitting a social and financial impact report on 2023 Senate Bill 743 and Assembly Bill 784 relating to insurance coverage and balance billing for certain health care services.

Coverage Mandates

OCI has determined that 2023 Senate Bill 743 and Assembly Bill 784 require a social and financial impact report for the following reasons:

1. Requires a particular benefit design or imposes conditions on cost-sharing under an insurance policy, plan, or contract for the treatment of a particular disease, condition, or other health care need, for a particular type of health care treatment or service, or for the provision of equipment, supplies, or drugs used in connection with a health care treatment or service.
2. Imposes limits or conditions on a contract between an insurer and a health care provider, as defined in s. 146.81 (1).

Social Impact

2023 Senate Bill 743 and Assembly Bill 784 will require 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 medical services without requiring a prior authorization determination and without regard to whether 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 an 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 calculated 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 items or services toward any in-network deductible or out-of-pocket maximum as if the cost-sharing payment was made for items or 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.

Under the bill, a provider or facility that is entitled to a payment for an emergency medical service or other item or service may initiate open negotiations with the defined network plan, preferred provider plan, or self-insured governmental health 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 because of a change in the terms of the participation of the provider or facility in the plan or the contract is terminated, resulting in a loss of benefits under the plan, the plan must notify the 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. If a continuing care patient would qualify for continued care for a longer period under current law than specified in the bill, the bill specifies that the continuing care patient may continue to receive coverage for the longer period provided under current law.

On January 1, 2022, the federal No Surprises Act (NSA) became law. The NSA protects you from surprise bills for covered emergency out-of-network services, including air ambulance services (but not ground ambulance services), and surprise bills for covered non-emergency services at an in-network facility. It applies to the self-insured health plans that employers offer as well as plans from health insurance companies. NSA provisions include:

- A facility (such as a hospital or freestanding emergency room (ER)) or a provider (such as a doctor) may not bill you more than your in-network coinsurance, copays, or deductibles for emergency services, even if the facility or provider is out-of-network.

- If your health plan requires you to pay copays, coinsurance, and/or deductibles for in-network care, you're responsible for those.

- The NSA also protects you when you receive non-emergency services from out-of-network providers (such as an anesthesiologist) at in-network facilities. An out-of-network provider may not bill you more than your in-network copays, coinsurance, or deductibles for covered services performed at an in-network facility.

- You can never be asked to waive your protections and agree to pay more for out-of-network care at an in-network facility for care related to emergency medicine, anesthesiology, pathology, radiology, or neonatology—or for services provided by assistant surgeons, hospitalists (doctors who focus on care of hospitalized patients), and intensivists (doctors who care for patients needing intensive care), or for diagnostic services including radiology and lab services.

- You still can agree in advance to be treated by an out-of-network provider in some situations, such as when you choose an out-of-network surgeon knowing the cost will be higher. The provider must give you information in advance about what your share of the costs will be. If you did that, you'd be expected to pay the balance bill as well as your out-of-network coinsurance, deductibles, and copays.

The NSA required the convening of an advisory committee tasked with reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing. The Advisory Committee on Ground Ambulance and Patient Billing (GAPB) has held several public meetings over the past year and will submit a report that includes recommendations for balance billing practices related to ground ambulances.

OCI is unable to definitively determine how many residents could benefit from the mandate on ground ambulance coverage proposed in this bill.

Financial Impact

OCI is unable to determine what the financial impact of the proposed bills would be on insurers.

OCI is unable to determine the extent to which these additional mandates could increase administrative and claims costs or how the proposed requirements on insurers may impact premium costs to consumers and employers.

Please contact Sarah Smith at (608) 209-6309 or Sarah.Smith2@wisconsin.gov if you have any questions.

Respectfully submitted,

Nathan Houdek
Commissioner

Cc: The Honorable Tony Evers, Governor of Wisconsin