



2019 SENATE BILL 313

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

- 1 **AN ACT to create** 609.07 of the statutes; **relating to:** billing practices for certain
2 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

SENATE BILL 313

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:

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

2 **609.07 Balance billing. (1) DEFINITIONS.** In this section:

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

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

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

SENATE BILL 313

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

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

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

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

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

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

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

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

SENATE BILL 313**SECTION 1**

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

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

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

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

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

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

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

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

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

SENATE BILL 313

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

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

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

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

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

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

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

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

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

SENATE BILL 313**SECTION 1**

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

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

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

8 **SECTION 2. Initial applicability.**

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

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

17 **SECTION 3. Effective date.**

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

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(END)