



2019 ASSEMBLY BILL 1016

March 24, 2020 - Introduced by Representatives KOLSTE, HEBL, ZAMARRIPA, STUBBS, BILLINGS, CABRERA, ANDERSON, SARGENT, SUBECK, BROSTOFF, BOWEN, SHANKLAND, NEUBAUER, SINICKI, CONSIDINE, OHNSTAD, HINTZ and VRUWINK, cosponsored by Senators SMITH and LARSON. Referred to Committee on Health.

1 **AN ACT** *to create* 609.07 of the statutes; **relating to:** imposing disclosure and
2 billing requirements for certain health care providers, creating an arbitration
3 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

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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 requires the commissioner to determine and establish a mechanism to cover the arbitration costs that are otherwise unpaid by enrollees.

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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:

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 2. Emergency services billed under American Medical Association Current
2 Procedural Terminology codes 99217 to 99220, 99224 to 99226, 99234 to 99236,
3 99281 to 99285, 99288, and 99291 to 99292 if the amount billed for a specific code
4 does not exceed 120 percent of the usual and customary cost for the code and does not
5 exceed the exemption amount. The exemption amount shall be \$600 in 2020 and
6 shall be adjusted annually by the commissioner to reflect changes in the consumer
7 price index for all urban consumers, U.S. city average, for the medical care group, as
8 determined by the U.S. department of labor, for the 12 months ending on December
9 31 of the preceding year, except that the exemption amount may not exceed \$1,200.

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

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

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

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

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

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

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

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

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

3 5. Individual characteristics of the enrollee.

4 6. The usual and customary cost of the service.

5 7. Any factors identified by the commissioner by rule.

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

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

12 (g) *Costs.* 1. For disputes submitted under par. (a), the costs for the arbitration
13 process shall be paid by the enrollee if the independent dispute resolution entity
14 determines that the fee charged by the provider to the enrollee is reasonable and by
15 the provider if the entity determines that the fee is not reasonable; except that the
16 costs charged to an enrollee may not exceed \$100. The commissioner may waive or
17 reduce the costs charged to the enrollee if requiring full payment would impose a
18 hardship on the enrollee. The commissioner shall, by rule, specify the factors to be
19 considered in making the determination of hardship and determine and establish a
20 mechanism to cover the amount of arbitration costs that are otherwise unpaid by
21 enrollees under this subdivision.

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

