

2007 BILL

1 **AN ACT** *to amend* 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t)
2 and 185.983 (1) (intro.); and *to create* 146.903, 609.71 and 632.798 of the
3 statutes; **relating to:** disclosure of information by health care providers,
4 insurers, and governmental self-insured plans; requiring acceptance by a
5 health care provider of a payment amount in certain circumstances; and
6 requiring the exercise of rule-making authority.

Analysis by the Legislative Reference Bureau

Under current law, as affected by 2007 Wisconsin Act 20 (the biennial budget act), if an applicant for Medical Assistance (MA) is determined to be eligible for MA retroactively (for three months) and a provider bills the applicant directly for services and benefits rendered during the retroactive period, the provider must submit MA claims for those services and benefits that are covered under MA. Upon receiving MA payment under the claims, the provider must reimburse the MA recipient, or other person who made the prior payment on behalf of the recipient, for services provided to the recipient during the retroactive eligibility period, by the amount of the prior payment made.

This bill restricts payment that a health care provider, as defined in the bill, may accept from certain patients who are uninsured or who do not have public coverage (as defined in the bill). If the patient, within 90 days after receiving a health care service, diagnostic test, procedure or the first treatment or visit of a course of

BILL

treatment as part of a health care service, obtains coverage from an insurer or a self-insured health plan under a contract for not less than one year, the health care provider must accept, as payment from the patient for the service, test, or procedure no more than the insurer's or plan's payment amount for that service, test, or procedure. However, the patient may be liable to the health care provider for out-of-pocket costs, finance charges, and collection costs incurred that would not have been covered under the patient's coverage. The insurer or self-insured health plan that provides coverage must provide to the patient a dollar estimate of the applicable payment amount for the service, test, or procedure the patient received. Also, under the bill, a health care provider must provide to a patient who is uninsured or does not have public coverage, at the time the health care service, test, or procedure is provided or after the first treatment or visit of a course of treatment, information about this restriction on payment and information about the restriction on acceptance of patient payment for MA applicants who receive retroactive eligibility.

Under the bill, if a health care provider recommends, refers for service, or prescribes a health care service (including any applicable course of treatment), diagnostic test, or procedure for which the charge exceeds \$500 or any higher amount that the Department of Health and Family Services (DHFS) promulgates by rule (the minimum cost), and if the patient or his or her agent requests an estimate of the charge, the health care provider must either: 1) for a patient who is insured or uninsured, provide an estimate of the charge to the patient or the patient's agent; or 2) for a patient who is insured, provide the patient's insurer or self-insured health plan with an estimate of the charge as the basis for information the insurer or self-insured health plan must provide on request of the insured. The estimate of the charge must be provided at the time of scheduling of the health care service, diagnostic test, procedure, or course of treatment, or within seven days of the request, whichever is later. The bill specifies numerous requirements for the estimate of charge, except that, in lieu of several of the requirements, a health care provider may provide to the patient or his or her agent an estimate of charge that is a single fixed price estimate of the total cost of the health care service, diagnostic test, or procedure, the amount of which the health care provider must accept as payment in full.

The bill requires DHFS, by rule, biennially to adjust the dollar amount that is specified for minimum cost and specifies a procedure, using the consumer price index, by which the adjusted dollar amount must be calculated. DHFS may promulgate the amount as an emergency rule without providing a finding of emergency or complying with certain other standards for promulgating emergency rules.

The bill requires a self-insured health plan of the state or a county, city, village, town, or school district, or an insurer that provides health care coverage under a health care plan, including a defined network plan or a sickness care plan operated by a cooperative association, to provide to an insured under the health care plan or an enrollee under the self-insured health plan, any of the following if requested by the insured or enrollee: 1) a description of the coverage, including benefits and

BILL

cost-sharing requirements, under the health care plan or self-insured health plan; 2) a description of any pre-certification or other requirements that an insured or enrollee must complete before any care is approved by the insurer or self-insured health plan; and 3) a summary of the insured's or enrollee's coverage with respect to a specific medical service or course of treatment. The summary of coverage is based on information relating to an estimate of a charge for a medical service or course of treatment that was provided by a provider or group of providers to the insured or enrollee or to the insurer or self-insured health plan and must include an estimate of the total out-of-pocket costs that the insured or enrollee may incur, an estimate of the amount that the insurer or self-insured health plan has paid to the provider or providers, any limits on what the insurer or self-insured health plan will pay if the service or course of treatment is received from a nonparticipating or out-of-network provider, and any discounts that the insurer or self-insured health plan is willing to offer the insured or enrollee if the service or course of treatment is received from a different provider. If the summary is based on estimate of charge information that was provided to the insurer or self-insured health plan, rather than to the insured or enrollee, the summary must include that estimate of charge information.

For further information see the *state and local* 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.** 40.51 (8) of the statutes, as affected by 2007 Wisconsin Act 36, is
2 amended to read:

3 40.51 **(8)** Every health care coverage plan offered by the state under sub. (6)
4 shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8)
5 and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855,
6 632.87 (3) to ~~(5)~~ (6), 632.895 (5m) and (8) to (15), and 632.896.

7 **SECTION 2.** 40.51 (8m) of the statutes, as affected by 2007 Wisconsin Act 36, is
8 amended to read:

9 40.51 **(8m)** Every health care coverage plan offered by the group insurance
10 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
11 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (15).

BILL

1 **SECTION 3.** 66.0137 (4) of the statutes, as affected by 2007 Wisconsin Act 36,
2 is amended to read:

3 66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
4 a village provides health care benefits under its home rule power, or if a town
5 provides health care benefits, to its officers and employees on a self-insured basis,
6 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
7 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87
8 (4) ~~and~~, (5), and (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

9 **SECTION 4.** 120.13 (2) (g) of the statutes, as affected by 2007 Wisconsin Act 36,
10 is amended to read:

11 120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss.
12 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
13 632.798, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to (15),
14 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

15 **SECTION 5.** 146.903 of the statutes is created to read:

16 **146.903 Disclosures required of health care providers. (1)** In this
17 section:

18 (a) “Ambulatory surgery center” has the meaning given in 42 CFR 416.2.

19 (b) “Average charged rate” means the average amount that is currently charged
20 by a health care provider to a patient for a health care service, diagnostic test, or
21 procedure.

22 (c) “Average paid rate” means the average amount that a health care provider
23 currently accepts as payment in full for a health care service, diagnostic test, or
24 procedure, after any discount applicable to certain patients is applied.

BILL

1 (d) “Clinic” means a place, other than a residence, that is used primarily for the
2 provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and
3 treatment.

4 (e) “Course of treatment” means, as part of a health care service, the
5 management and care, including related therapy and rehabilitation, of a patient
6 over time for the purpose of combating disease or disorder or temporarily or
7 permanently relieving symptoms.

8 (f) “Health care plan” has the meaning given in s. 628.36 (2) (a) 1.

9 (g) “Health care provider” has the meaning given in s. 146.81 (1) and includes
10 a clinic and an ambulatory surgery center.

11 (h) “Health care service, diagnostic test, or procedure” includes physical
12 therapy, speech therapy, occupational therapy, chiropractic treatment, or mental
13 therapy.

14 (i) “Insured” means covered under a health care plan offered by an insurer or
15 under a self-insured health plan.

16 (j) “Insurer” means an insurer that is authorized to do business in this state,
17 in one or more lines of insurance that includes health insurance, and that provides
18 coverage, excluding public coverage, of health care expenses under health care plans
19 covering individuals or groups in this state. The term includes a health maintenance
20 organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s.
21 609.01 (4), an insurer operating as a cooperative association organized under ss.
22 185.981 to 185.985, and a limited service health organization, as defined in s. 609.01
23 (3).

24 (k) “Medical Assistance” means aid provided under subch. IV of ch. 49, other
25 than aid under s. 49.471.

BILL

1 (L) “Medicare” means coverage under Part A or Part B of Title XVIII of the
2 federal social security act, 42 USC 1395 to 1395hhh.

3 (m) “Mental therapy” includes services and treatment for mental illness,
4 developmental disability, alcohol and other drug abuse, and drug dependence.

5 (n) “Minimum cost” means \$500 or any higher amount that is specified by the
6 department by rule.

7 (p) “Patient’s agent” means the parent, guardian, or legal custodian of a minor
8 patient; the spouse of a patient; an agent of a patient under a valid power of attorney
9 for health care; a guardian of the person, as defined in s. 54.01 (12) of a patient; or
10 any individual who is authorized by the patient to act as his or her agent.

11 (q) “Public coverage” means coverage for health care expenses that is funded
12 in whole or in part under any state–assisted or federally assisted program other than
13 BadgerCare Plus under s. 49.471, including Medical Assistance and Medicare, for
14 which the average reimbursement rate for a health care service, diagnostic test, or
15 procedure is lower than an insurer’s or self–insured health plan’s average paid rate
16 for the identical service, test, or procedure.

17 (r) “Self–insured health plan” has the meaning given in s. 632.745 (24).

18 **(2)** (a) If a patient is not insured or does not have public coverage at the time
19 he or she first receives a particular health care service, diagnostic test, or procedure
20 or the first treatment or visit of a course of treatment and, within 90 days after
21 receipt of the service, test, procedure, or treatment, obtains from an insurer or a
22 self–insured health plan coverage that is under a contract for not less than one year,
23 the health care provider shall accept, as payment from the patient for the service,
24 test, or procedure provided to the patient, no more than the insurer’s or plan’s
25 payment amount for that service, test, or procedure, except that the patient may be

BILL

1 liable to the health care provider for any out-of-pocket costs, finance charges, and
2 collection costs incurred that would not have been covered under the patient's
3 coverage.

4 (b) The health care provider of a patient who is not insured or who does not have
5 public coverage at the time that a health care service, diagnostic test, or procedure
6 is provided or after the first treatment or visit of a course of treatment shall inform
7 the patient of the requirement under par. (a) and of the provider's reimbursement
8 requirement for a recipient of Medical Assistance under s. 49.49 (3m) (a) 2.

9 (c) The insurer or self-insured health plan that provides coverage specified
10 under par. (a) shall provide to the patient a dollar estimate of the insurer's or plan's
11 applicable payment amount for the health care service, diagnostic test, or procedure
12 received by the patient, as specified under par. (a).

13 **(3)** (a) If a health care provider recommends, refers for service, or prescribes
14 a health care service, including any applicable course of treatment, or diagnostic test
15 or procedure for which the charge exceeds the minimum cost, and if a patient or the
16 patient's agent requests an estimate of the charge, the health care provider or group
17 of health care providers jointly, if applicable, shall do one of the following:

18 1. For a patient who is insured or who is not insured, provide the patient or the
19 patient's agent with an estimate of the charge.

20 2. For a patient who is insured, provide the patient's insurer or self-insured
21 health plan with an estimate of the charge as the basis for complying with the
22 insured's request under s. 632.798.

23 (b) Except as provided in par. (c) 2., for an estimate of the charge that is
24 provided under par. (a), the health care provider or group of health care providers
25 jointly, if applicable, shall provide the following, as applicable, at the time of

BILL

1 scheduling of the health care service, diagnostic test, procedure, or course of
2 treatment or within 7 days of the request, whichever is later:

3 1. For an inpatient surgical procedure and course of treatment, an estimate of
4 the charge that shall include all of the following:

5 a. The reasonably anticipated services of health care providers who will likely
6 provide health care services, during and after the surgical procedure and during any
7 related course of treatment.

8 b. The reasonably anticipated total charge for hospitalization, daily charge for
9 hospitalization, and number of days of hospital stay.

10 2. For an outpatient surgical procedure and course of treatment, an estimate
11 of the charge that shall include the reasonably anticipated total charge.

12 3. For an inpatient or outpatient surgical procedure and course of treatment,
13 objective quality data that is related to the health outcome of the proposed procedure
14 and course of treatment, if the health care provider has made public the data.

15 4. For a nonsurgical hospital procedure and course of treatment, an estimate
16 of the charge that shall include the reasonably anticipated services of health care
17 providers who will likely provide health care services during and after the procedure
18 and any related course of treatment.

19 5. For physical therapy, speech therapy, occupational therapy, chiropractic
20 treatment, or mental therapy, an estimate of the charge that shall include all of the
21 following:

22 a. A proposed treatment plan that describes the number and frequency of visits
23 of a course of treatment and the anticipated charges for the course of treatment. If
24 the course of treatment is anticipated to exceed 6 months and if the patient or the

BILL

1 patient's agent so requests, the health care provider shall provide an estimate of the
2 charge and course of treatment plan for each anticipated 6 month period.

3 b. Objective quality data that is related to the health outcome of the proposed
4 course of treatment, if the health care provider has made public the data.

5 (c) 1. All of the following applies to an estimate of the charge provided under
6 this subsection:

7 a. The estimate of the charge shall represent the good-faith effort of a health
8 care provider or group of health care providers jointly, if applicable, to provide
9 accurate information to the patient or the patient's agent.

10 b. The estimate of the charge shall inform the patient of his or her
11 responsibilities in complying with any medical requirements for the patient that are
12 associated with any health care service, diagnostic test, or procedure proposed; and
13 the potential of cost variances that are due to factors that cannot reasonably be
14 anticipated.

15 c. The estimate of the charge shall indicate how the health status of the patient
16 may contribute to any charge variances that may reasonably be anticipated.

17 d. The estimate of the charge shall include any discounts or financial incentives
18 the health care provider or group of health care providers jointly, if applicable, offers
19 for obtaining a health care service, diagnostic test, or procedure that is provided by
20 the health care provider.

21 e. The estimate of the charge shall include a written description of the health
22 care service, diagnostic test, or procedure that includes the appropriate medical code
23 or codes that will enable the patient or patient's agent to obtain applicable coverage
24 payment information from an insurer or self-insured health plan.

BILL

1 f. The estimate of the charge shall include the identity of the health care
2 provider or the individual identities of the group of health care providers, if
3 applicable, and the address of the applicable facility with which each health care
4 provider is associated.

5 g. The estimate of the charge may, if requested by the patient or the patient's
6 agent, be issued electronically.

7 2. In lieu of the requirements under par. (b), a health care provider or group of
8 health care providers jointly, if applicable, may provide to the patient or the patient's
9 agent an estimate of the charge that is a single fixed-price estimate of the total cost
10 of the health care service, diagnostic test, or procedure, the amount of which the
11 health care provider shall accept as payment in full.

12 3. All of the following applies to an estimate of the charge provided under this
13 subsection for a patient who is insured:

14 a. The health care provider or group of health care providers jointly, if
15 applicable, may provide the average paid rate paid by insurers and self-insured
16 health plans, the average charged rate billed to insurers and plans, or a rate that is
17 lower than the average charged rate billed to private insurers, if each rate that is
18 provided is clearly labeled in the estimate of the charge.

19 b. The estimate of the charge shall contain language that encourages the
20 patient to review the estimate carefully and to contact his or her insurer or
21 self-insured health plan for specific coverage information.

22 4. All of the following applies to an estimate of the charge provided under this
23 subsection for a patient who is not insured:

24 a. If the health care provider determines, on the basis of preliminary
25 information, that the patient is eligible for Medical Assistance or is eligible for but

BILL

1 not enrolled in Medicare and the health care provider accepts recipients of Medical
2 Assistance or beneficiaries of Medicare, the estimate of the charge shall include the
3 average paid rate paid by insurers and self-insured health plans or a rate lower than
4 that rate; shall contain language that encourages the patient to review the estimate
5 carefully and to apply for Medical Assistance or enroll in Medicare, as applicable; and
6 shall inform the patient or the patient's agent of the requirements of s. 49.49 (3m)
7 (a) 2.

8 b. If the health care provider cannot determine if the patient is eligible for
9 Medical Assistance or Medicare, the estimate of the charge shall include the average
10 paid rate paid by insurers and self-insured health plans or a rate lower than that
11 rate; shall contain language that encourages the patient to review the estimate
12 carefully and to obtain insurance coverage; and shall inform the patient or the
13 patient's agent of the terms and conditions under which the average paid rate or
14 another paid rate may be applicable.

15 **(4)** (a) In this subsection, "consumer price index" means the average of the
16 consumer price index over each 12-month period, all items, U. S. city average, as
17 determined by the bureau of labor statistics of the U. S. department of labor.

18 (b) The department shall, by rule, biennially adjust the dollar amount that is
19 specified for minimum cost under sub. (1) (n) by calculating any percentage
20 difference between the consumer price index for the 12-month period ending on
21 December 31 of the most recent odd-numbered year and the consumer price index
22 for the 12-month period ending on December 31 of the next most recent
23 odd-numbered year and applying that percentage difference, if any, to the
24 most-recently specified dollar amount for minimum cost under this subsection or
25 sub. (1) (n). If a percentage difference exists, the department shall by rule prescribe

BILL

1 a revised dollar amount, rounded to the nearest \$50 increment, that reflects the
2 percentage difference, which amount shall be in effect until a subsequent rule is
3 promulgated under this subsection. Notwithstanding s. 227.24 (1) (a), (2) (b), or (3),
4 the department is not required to provide evidence that promulgating a rule under
5 this subsection as an emergency rule is necessary for the preservation of the public
6 peace, health, safety, or welfare and is not required to provide a finding of emergency
7 for a rule promulgated under this subsection.

8 **SECTION 6.** 185.981 (4t) of the statutes, as affected by 2007 Wisconsin Act 36,
9 is amended to read:

10 185.981 (4t) A sickness care plan operated by a cooperative association is
11 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798,
12 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), and (5), and (6), 632.895 (10) to (15),
13 and 632.897 (10) and chs. 149 and 155.

14 **SECTION 7.** 185.983 (1) (intro.) of the statutes, as affected by 2007 Wisconsin
15 Act 36, is amended to read:

16 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be
17 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
18 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
19 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,
20 632.853, 632.855, 632.87 (2m), (3), (4), and (5), and (6), 632.895 (5) and (9) to (15),
21 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring
22 association shall:

23 **SECTION 8.** 609.71 of the statutes is created to read:

24 **609.71 Disclosure of payments.** Limited service health organizations,
25 preferred provider plans, and defined network plans are subject to s. 632.798.

BILL

1 **SECTION 9.** 632.798 of the statutes is created to read:

2 **632.798 Disclosure of information. (1) DEFINITIONS.** In this section:

3 (a) “Cost-sharing requirements” means copayments, deductibles, coinsurance
4 percentages, and any other cost-sharing mechanisms that apply under a health care
5 plan or self-insured health plan.

6 (b) “Health care plan” has the meaning given in s. 628.36 (2) (a) 1.

7 (c) “Insured” means a person covered under a health care plan offered by an
8 insurer or an enrollee under a self-insured health plan.

9 (d) “Insured’s agent” means a parent, guardian, or legal custodian of an insured
10 who is a minor child; the spouse of an insured; an agent of an insured under a valid
11 power of attorney for health care; a guardian of the person, as defined in s. 54.01 (12),
12 of an insured; or anyone authorized by an insured to act as his or her agent.

13 (e) “Insurer” means an insurer that is authorized to do business in this state,
14 in one or more lines of insurance that includes health insurance, and that provides
15 coverage, excluding public coverage, of health care expenses under health care plans
16 covering individuals or groups in this state. The term includes a health maintenance
17 organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s.
18 609.01 (4), an insurer operating as a cooperative association organized under ss.
19 185.981 to 185.985, and a limited service health organization, as defined in s. 609.01
20 (3).

21 (f) “Participating” has the meaning given in s. 609.01 (3m).

22 (g) “Provider” means a health care provider, as defined in s. 146.81 (1).

23 (h) “Public coverage” means coverage for health care expenses that is funded
24 in whole or in part under any state-assisted or federally assisted program, including
25 Medical Assistance under subch. IV of ch. 49 and Medicare under 42 USC 1395 to

BILL

1 1395hhh, the average paid rate of which is lower than an insurer's average paid rate
2 for the same medical service.

3 (i) "Self-insured health plan" has the meaning given in s. 632.745 (24).

4 **(2) INFORMATION REQUIRED.** An insurer or self-insured health plan shall provide
5 any of the following information if requested by an insured or an insured's agent:

6 (a) A description of the coverage, including benefits and cost-sharing
7 requirements, under the insured's health care plan or self-insured health plan.

8 (b) A description of pre-certification or other requirements, if any, that an
9 insured must complete before any care is approved by the insurer or self-insured
10 health plan.

11 (c) Based on the information relating to an estimate of the charge that was
12 provided under s. 146.903 (3) (a), a summary of the insured's coverage with respect
13 to a specific medical service or course of treatment, including all of the following
14 information:

15 1. The estimated total and type of out-of-pocket costs that the insured may
16 incur, including deductibles, copayments, coinsurance, and items and other charges
17 that are not covered by the insurer or self-insured health plan.

18 2. An estimate of the amount that the insurer or self-insured health plan paid
19 to a provider or providers for the specific medical procedure or course of treatment.
20 The estimate under this subdivision may provide the payment amount or rate in such
21 a way that protects the insurer's proprietary pricing, but shall be a reasonably close
22 estimate of the actual amount or rate paid.

23 3. Any limits on what the insurer or self-insured health plan will pay if the
24 service or course of treatment is received from a provider that is not a participating
25 provider. If the insured provides to the insurer or self-insured health plan the

BILL

1 applicable medical code or codes for the service or course of treatment provided or
2 proposed to be provided by a provider or providers that are not participating, the
3 insurer or self-insured health plan shall inform the insured if the cost of the service
4 or course of treatment exceeds the allowable charge under the insurer's or
5 self-insured health plan's guidelines for payment for the service or course of
6 treatment under the insured's health care plan or self-insured health plan.

7 4. Any discounts or financial incentives that the insurer or self-insured health
8 plan is willing to offer the insured, including incentives for the insured to obtain care
9 or a course of treatment from a different provider.

10 5. That the information in the summary is based on the information relating
11 to the estimate of the charge that was provided to the insured or to the insurer or
12 self-insured health plan under s. 146.903 (3) (a).

13 6. The information relating to the estimate of the charge that was provided to
14 the insurer under s. 146.903 (3) (a) 2., if the provider or group of providers, if
15 applicable, has provided that information to the insurer or self-insured health plan,
16 rather than to the insured.

17 7. That the information in the summary represents only an estimate and is not
18 a legally binding contract or guarantee of the amounts provided in the summary.

19 **(3) GENERAL PROVISIONS.** (a) The information under sub. (2) may be provided
20 to the insured electronically or verbally, whichever is preferred by the insured.

21 (b) The insurer or self-insured health plan shall make a good faith effort to
22 provide accurate information to the insured under sub. (2).

SECTION 10. Initial applicability.

23
24 (1) DISCLOSURE OF INFORMATION. If a health care plan or a governmental
25 self-insured health plan that is in effect on the effective date of this subsection, or

BILL

1 a contract or agreement between a health care provider and a health care plan that
2 is in effect on the effective date of this subsection, contains a provision that is
3 inconsistent with this act, this act first applies to that health care plan,
4 governmental self-insured health plan, or contract or agreement on the date on
5 which it is modified, extended, or renewed.

6 **SECTION 11. Effective date.**

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

9 (END)