

ALEC EXPOSED

"ALEC" has long been a secretive collaboration between Big Business and "conservative" politicians. Behind closed doors, they ghostwrite "model" bills to be introduced in state capitols across the country. This agenda-underwritten by global corporations—includes major tax loopholes for big industries and the super rich, proposals to offshore U.S. jobs and gut minimum wage, and efforts to weaken public health, safety, and environmental protections. Although many of these bills have become law, until now, their origin has been largely unknown. With **ALEC EXPOSED**, the Center for Media and Democracy hopes more Americans will study the bills to understand the depth and breadth of how big corporations are changing the legal rules and undermining democracy across the nation.

ALEC's Corporate Board --in recent past or present

- AT&T Services, Inc.
 - centerpoint360
 - UPS
 - Bayer Corporation
 - GlaxoSmithKline
 - Energy Future Holdings
 - Johnson & Johnson
 - Coca-Cola Company
 - PhRMA
 - Kraft Foods, Inc.
 - Coca-Cola Co.
 - Pfizer Inc.
 - Reed Elsevier, Inc.
 - DIAGEO
 - Peabody Energy
 - Intuit, Inc.
 - Koch Industries, Inc.
 - ExxonMobil
 - Verizon
 - Reynolds American Inc.
 - Wal-Mart Stores, Inc.
 - Salt River Project
 - Altria Client Services, Inc.
 - American Bail Coalition
 - State Farm Insurance
- For more on these corporations, search at www.SourceWatch.org.

DID YOU KNOW? Corporations VOTED to adopt this. Through ALEC, global companies work as "equals" in "unison" with politicians to write laws to govern your life. Big Business has "a VOICE and a VOTE," according to newly exposed documents. **DO YOU?**

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Patient's Right to Know Act

Section 1. Title. This Act shall be known as the "Patient's Right to Know Act."

Section 2. Purpose. The purpose of this legislation is to provide health care consumers with better information on the cost of their medical care and to introduce elements of competition into the marketplace.

Section 3. Applicability and Scope. This legislation shall apply to all providers of medical care in this state, and any health maintenance organization or health insurer conducting business in this state, and self-insured health plans offered by any unit of government in this state.

Section 4. Definitions. As used in this Act, the following definitions apply:

A. "Ambulatory Surgical Center" has the meaning given in federal law (42 CFR 416.2).

B. "Average paid rate" means the average amount that a health care provider currently accepts as payment in full for a health care service, diagnostic test, or procedure, after any discount applicable to certain patients is applied.

C. "Charged rate" means the average, median, or actual amount that is currently charged by a health care provider to a patient for a health care service, diagnostic test, or procedure.

D. "Clinic" means a place, other than a residence, that is used primarily for the provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and treatment.

E. "Cost-sharing requirements" means copayments, deductibles, coinsurance percentages, and any other cost-sharing mechanisms that apply under a health care plan or self-insured health plan.

E. "Course of treatment" means, as part of a health care service, the management and care, including related therapy and rehabilitation, of a patient over time for the purpose of combating disease or disorder or temporarily or permanently relieving symptoms.

F. "Health care plan" means health insurance plans offered by entities specified in Section 3.

G. "Health care provider" or "provider" means providers of medical care in this state and includes a clinic and an ambulatory surgery center.

I. "Health care service," "diagnostic test," or "procedure" includes physical therapy, speech therapy, occupational therapy, chiropractic treatment, or mental therapy, but does not include a prescription drug.

J. "Insured" means covered under a health care plan offered by an insurer or under a self-insured health plan.

K. "Insured's agent" means a parent, guardian, or legal custodian of an insured who is a minor child; the spouse of an insured; an agent of an insured under a valid power of attorney for health care; a guardian of the person, or anyone authorized by an insured to act as his or her agent.

L. "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance and is included in Section 3.

M. "Mental therapy" includes services and treatment for mental illness, developmental disability, alcohol and other drug abuse, and drug dependence.

N. "Minimum cost" means \$500 or any higher amount that is specified by departmental rule that adjusts for inflation.

O. "Out-of network" means any treatment received from a medical care provider that is not a member of the patient's preferred network.

Did you know that big pharma company Bayer Healthcare was the corporate co-chair in 2011?

P. "Patient's agent" means the parent, guardian, or legal custodian of a minor patient; the spouse of a patient; an agent of a patient under a valid power of attorney for health care; a guardian of the person, or any individual who is authorized by the patient to act as his or her agent.

Section 5. Disclosures Required of Health Care Providers. If a patient is recommended to, referred to, or is under the care of a health care provider or group of health care providers for a health care service, including any applicable course of treatment, or diagnostic test or procedure for which the charge exceeds the minimum cost, and if the patient or the patient's agent requests an estimate of the charge, the health care provider or group of health care providers, if applicable, shall provide the patient or the patient's agent with an estimate of the charge of the provider and provider groups as used in this Section.

A. Except as provided in Paragraph B, an estimate of the charge shall provide the following, as applicable, at the time of scheduling of the health care service, diagnostic test, procedure, or course of treatment or within 10 business days of the request, whichever is later:

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

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

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

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

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

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

a. A proposed treatment plan that describes the number and frequency of visits of a course of treatment and the anticipated charges for the course of treatment. If the course of treatment is anticipated to exceed 6 months and if the patient or the patient's agent so requests, the health care provider shall provide an estimate of the charge and course of treatment plan for each anticipated 6 month period.

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

B. In lieu of the requirements under Paragraph A, a health care provider or group of health care providers, if applicable, may provide to the patient or the patient's agent an estimate of the charge that is a single fixed-price estimate of the total cost of the health care service, diagnostic test, or procedure.

C. All of the following applies to an estimate of the charge provided under this Section:

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

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

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

4. The estimate of the charge shall include any discounts or financial incentives the health care provider or group of health care providers, if applicable, are willing to offer to the patient for obtaining a health care service, diagnostic test, or procedure that is provided by the health care provider or group of health care providers.

5. The estimate of the charge shall include a description of the health care service, diagnostic test, or procedure that includes the appropriate medical code or codes that will enable the patient or patient's agent to obtain applicable coverage payment information under Section 6 from an insurer or self-insured health plan.

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

7. The estimate of the charge may, if requested by the patient or the patient's agent, be issued electronically.
8. The estimate of the change is not a binding or implied contract upon the parties and is not a guarantee that the amounts estimated will be charged.
9. The estimate of the charge shall contain language that encourages the patient to review the estimate carefully and to contact his or her insurer or self-insured health plan for specific coverage information.

Section 6. Disclosures Required of Health Insurers. An insurer or self-insured health plan shall provide any of the following information if requested by an insured or an insured's agent:

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

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

C. Based on the information relating to an estimate of the charge that was provided to the insured or insured's agent under Section 5, a summary of the insured's coverage with respect to a specific medical service or course of treatment, including all of the following information:

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

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

c. Any limits on what the insurer or self-insured health plan will pay if the service or course of treatment is received from an "out-of-network" provider. If the insured provides to the insurer or self-insured health plan the applicable medical code or codes for the service or course of treatment provided or proposed to be provided by a provider or providers that are not participating, the insurer or self-insured health plan shall inform the insured if the cost of the service or course of treatment exceeds the allowable charge under the insurer's or self-insured health plan's guidelines for payment for the service or course of treatment under the insured's health care plan or self-insured health plan.

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

e. That the information in the summary is based on the information relating to the estimate of the charge that was provided to the insured or insured's agent under Section 5.

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

D. The information in this Section may be provided to the insured in writing, orally, or electronically, whichever is preferred by the insured.

E. The insurer or self-insured health plan shall make a good faith effort to provide accurate information to the insured under this Section.

Section 7. Initial Applicability. If a health care plan or a governmental self-insured health plan that is in effect on the effective date of this Section, or a contract or agreement between a health care provider and a health care plan that is in effect on the effective date of this Section, contains a provision that is inconsistent with this Act, this Act first applies to that health care plan, governmental self-insured health plan, or contract or agreement on the date on which it is modified, extended, or renewed.

Section 8. {Severability Clause}

Section 9. {Repealer Clause}

Were your laws repealed?

Section 10. Effective Date. This Act takes effect on the first day of the 25th month beginning after publication.

*Adopted by the Health and Human Services Task Force
May 1, 2009.*

*Approved by the American Legislative Exchange Council's Board of Directors
June 6, 2009.*

Exposed

By the Center for
Media and Democracy
www.prwatch.org

Center for Media and
Democracy's quick summary

The "Right to Know" Act would require all healthcare providers to provide patients with "good faith" estimates of the cost of all proposed care. It also requires insurers to inform their insured, upon request, what they will pay for a particular medical service or course of treatment, less any cost-saving requirements. This information is especially useful to those who have high-deductible insurance plans (with or without some form of health savings account), but can be useful to those with standard plans.

Wisconsin Senator Leah Vukmir is currently seeking co-sponsors for a bill that is clearly based on the ALEC model, including identical wording: <http://www.leahvukmir.com/site/Viewer.aspx?iid=22799&mname=Article&rpId=5914>