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Wisconsin Hospital Association Opposition to Senate Bill 383
Christian Moran, Vice President, Medicaid & Payer Reimbursement Policy

Senate Committee on Licensing, Regulatory Reform, State and Federal Affairs
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Good morning Chair Kapenga, Ranking Member Drake and members of the Committee.

My name is Christian Moran and I serve as the Wisconsin Hospital Association's Vice President of Medicaid & Payer Reimbursement Policy.

WHA is the state's leading healthcare advocacy organization, representing Wisconsin's hospitals and health systems. Wisconsin is fortunate to have some of the nation's highest performing rural and urban hospitals, an asset to our economy and the businesses that are seeking a highly skilled workforce. Our members are proud to be strong partners with business in local communities all across the state.

I'm honored to sit here next to two distinguished long-time hospital leaders who lead rural Critical Access Hospitals. Brian Stephens, Chief Executive Officer of Door County Medical Center and 2026 WHA Board Chair, and John Russell, President and CEO of Prairie Ridge Health based in Columbus, Wisconsin and past Chair of the Association.

Today, we are here testifying against the state-level requirements created in Senate Bill 383. Our opposition is not to price transparency. In fact, Wisconsin was one of the first states in the country to make hospital charge information accessible to consumers through WHA's PricePoint platform.

Our opposition to Senate Bill 383 is related to the added regulatory complexity that is created by layering on state-level enforcement, added state-level regulations and **unlimited** fines on Wisconsin hospitals when robust federal regulation and enforcement already exists.

Wisconsin's hospitals have long been leaders in both price and quality transparency, a commitment that remains today. While the task of complying with federal price

transparency regulations is not easy, Wisconsin lawmakers should be proud of our state's hospitals and their track record.

Since these federal regulations first went into effect in 2019, not a single Wisconsin hospital has been fined for noncompliance. While proponents of this legislation had originally justified this proposed state-level regulation by falsely stating that hospitals in Wisconsin were simply paying their fines and "walking away" from federal requirements, the legislature learned last session, during a lengthy public hearing in the Senate Health Committee, that this claim was simply not true.

Last session, the claim was also made that the federal government was not enforcing hospital price transparency regulations. One of the authors stated in testimony that enforcement was "almost entirely nonexistent at the federal level." This claim, also untrue, is easily refuted by available data.

Between January 7, 2021 and June 30, 2025, the federal Centers for Medicare and Medicaid Services conducted over 6,000 audits and enforcement actions related to hospital price transparency compliance. Nearly all of these cases resulted in a hospital coming into compliance, with only 27 hospitals receiving a fine.

While plenty of data exists about hospital compliance from CMS, **to date there is no government source of enforcement data for health insurance plans and third-party administrators with the Transparency in Coverage (TiC) requirements.** As the Senate Health Committee correctly realized last session, the hospital-focused legislation before you today in Senate Bill 383 is **focusing on the wrong "problem"**.

According to a December 11, 2025, Axios article titled *"Big insurers provide incomplete transparency data",* the authors acknowledge that **CMS hasn't taken enforcement action against insurers** and that federal regulators have previously said "states would be the primary enforcer of the requirements."

Yet, the "solution" proposed to you in Senate Bill 383 is to double-up on existing enforcement for hospitals while ignoring the state's current responsibility to enforce and monitor insurance company compliance with federal Transparency in Coverage (TiC) requirements.

Besides the glaring policy problems in Senate Bill 383, there are some fundamental philosophical inconsistencies and messaging contradictions being used as an attempt to justify state-level regulations and enforcement on hospitals.

Proponents of Senate Bill 383 are attempting to persuade you into believing that the efficacy of federal price transparency regulation is based on the number of fines levied by

the government. This is inconsistent with the philosophies many, if not all, of you have on the role of government regulation in business.

If a business is notified that they are out of compliance with a regulation, they should be given the opportunity to correct that action before the government moves forward with levying fines. In many instances, the regulated entity needs to provide feedback to its regulator on how to best implement its own policy -- something the Trump Administration recently did again in May 2025 when it sought public input on ways to improve federal hospital price transparency processes through a Request for Information.

If a business then comes into compliance, as **all Wisconsin hospitals have done when notified by CMS**, then the regulation, enforcement and response by the regulated industry is working. **Enforcement efficacy should not be judged on the number of fines, but how many hospitals come into compliance with regulations.**

The fact that 6,000 enforcement or audit actions by CMS have resulted in only 27 hospitals across the country receiving a fine is indicative of an industry that is taking its regulatory compliance obligation seriously.

History on Federal Healthcare Price Transparency Regulations

But before we go further, let's provide this Committee with additional background on federal healthcare price transparency regulations. This is history that the Senate Health Committee learned last session, causing them to not advance a previous iteration of this bill, so it is worth repeating to this Committee.

In 2019, the Trump Administration established new federal regulations requiring **hospitals**, **insurance companies** and **third-party administrators** to disclose pricing information to the public. While hospitals were expected to comply with this regulation by 2021, insurance companies and third-party administrators were granted another year to come into compliance with their regulation (frequently referred to as *Transparency in Coverage*).

These regulations have evolved significantly over time, as we stated in a memo to the legislature in June 2025, the following are just some of the changes since the inception of federal hospital price transparency regulations:

- Fines on noncompliant hospitals doubled by the Biden Administration – November 2021
- CMS assessed automatic civil monetary penalties for hospitals missing corrective action plan deadlines – April 2023
- CMS shortened the timeline between identifying a deficiency to penalties – April 2023

- Hospitals must affirm data is complete, accurate and submitted in good faith – January 2024
- Addition of "Price Transparency" link in the footer of the hospital homepage – January 2024
- Addition of a .txt file in the root folder of a hospital website with specific information – January 2024
- Development and use of a standardized CMS template (CSV or JSON) for MRFs – July 2024
- Hospitals must calculate and display an estimated allowed amount when negotiated rates are based on a percentage or algorithm – January 2025
- Hospitals must include drug unit of measurement, drug type of measure and modifiers to billing variations - January 2025
- Changes to the estimated allowed amount data field – May 2025

In addition, the federal Medicare Outpatient Prospective Payment System (OPPS) rule makes additional changes that were effective January 1, 2026:

- Replace the estimated allowed amount with the median allowed amount and add the 10th and 90th percentile allowed amounts.
- Include the hospital's National Provider Identification number
- Encode the name of the hospital CEO, president, or senior official designated to oversee the encoding of true, accurate, and complete data.

These files, which include payer-specific and service-specific pricing data, can contain millions of individual cells. As the federal regulation intended, these files are in formats that are be read by computers – hence the name "machine readable files".

In addition to this "machine readable file" requirement, hospitals are also required to provide a list of 300 "shoppable" services. Hospitals can meet this requirement by providing a web-based price estimator tool, which is the preferred method for patients to receive pricing information. Additionally, many of these price estimator tools are a component of the hospital or health systems' electronic health record (EHR) systems.

For those who are uninsured or who pay cash without utilizing an insurance network, Wisconsin hospitals are already required to provide a good faith estimate to patients through the federal *No Surprises Act*. If final billed charges for any care are $400 or more above the total amount in the good faith estimate, the patient may initiate a patient-provider dispute resolution process.

Last session, one proponent of legislation like Senate Bill 383 claimed in testimony that, *"Many hospitals across the country and in Wisconsin are simply ignoring the rule or are putting up poor attempts that neither comply with the letter, much less the spirit, of the rule."* Nothing could be further from the truth.

Hospitals across Wisconsin have provided patients with price transparency tools that far exceed their obligations under federal regulation. Due to advancements in technology and integration with electronic health records systems, hospitals and health systems have increasingly utilized "push" estimates to patients. A "push" estimate is proactively sent to patients in advance of their service without the patient requesting it.

Hospitals are also deploying price estimate technology that incorporates the patient's insurance-specific information into their estimate. While this is information that should be provided directly by the patient's health insurance company, hospitals are attempting to give patients more accurate price estimates that reflect their true out-of-pocket exposure.

Senate Bill 383 Remains Focused on the Wrong Problem

In a June 12th memo, proponents of Senate Bill 383 argue that constituents face out-of-pocket expenses and that the lack of transparency pricing "prevents them from making informed decisions about how to spend their healthcare dollars." This statement shows a fundamental misunderstanding of how patients access the healthcare system and who should make quality and pricing data available to these patients.

For any insured patient, decisions about their care provider are driven entirely by the patient's insurance network. Let me repeat this - the insured patient, those subject to out-of-pocket costs from their insurer, has **little choice** but to see providers within their network.

If they want to see a provider outside of their network by "shopping around", they will have to undergo a lengthy prior authorization process or pay completely out of pocket, which is not subject to the enrollee's health insurance deductible. In fact, it may be to a patient's financial detriment to "shop around" if they ignore their insurance company's network of providers and they need additional care throughout the rest of their plan year.

If a patient does choose to go outside their network, the healthcare provider or hospital often assists patients in the prior authorization process so the patient does not face an out-of-network bill for this service. Hospitals spend significant resources doing this activity. At UW Health alone, over 60 full-time equivalent staff are dedicated to working on prior authorization to assist patients so they don't receive a bill for a service that isn't approved or is out-of-network.

With this in mind, where should insured patients, who comprise 96% of Wisconsin's population, be getting information about the cost and quality of providers in their insurance network? This information should come from the patient's insurer. That is precisely why the

Trump Administration included insurance companies and third-party administrators in their federal price transparency requirements.

Yet, Senate Bill 383, like its failed predecessor from last session, **continues to completely ignore the federal requirements that exist for insurance companies to provide pricing information to patients.**

Self-Funded Employers Begging for Claims Data From TPAs, Resort to Lawsuits

As was made clear in October 2023 when this legislation was heard in the Senate Health Committee, employers testified they were using existing hospital price transparency data to hold their third-party administrators accountable to their stated discounts with hospitals. One employer even said, "we can't go against insurance companies if we don't have the data."

This was a revelation to many who were sitting in the room. As Wisconsin hospitals worked diligently to publicly post price transparency files in a constantly changing federal format, employers did not have access to their very own claims data.

Some employers have actually sued their third-party administrators for access to their own employee claims data. As we've done in the past, WHA encourages lawmakers to address this real issue.

Conclusion

WHA's concerns and opposition to Senate Bill 383 stems from decades of experience with conflicting state and federal hospital regulations. Not only can the regulations differ, but the interpretation of the same wording can also vary by individual surveyor.

In 2014, the legislature and then Governor Scott Walker acknowledged this quandary by enacting Wisconsin Act 236, legislation introduced by then-Representative Howard Marklein and State Senator Leah Vukmir, sunsetting state hospital regulations that were duplicative or conflicting with federal Medicare Conditions of Participation for hospitals.

Senate Bill 383 goes in the exact opposite direction, creating a state-level enforcement mechanism, unilateral authority for the DHS Secretary to impose state-level regulations and unlimited fines on hospitals.

WHA asks the Committee to reject Senate Bill 383.