



2007 ASSEMBLY BILL 729

January 24, 2008 - Introduced by Representatives WIECKERT, MOULTON, HRAYCHUCK, M. WILLIAMS, MOLEPSKE, VAN ROY, MUSSER, SHILLING, MURTHA, MONTGOMERY, F. LASEE, GUNDERSON, KESTELL, FIELDS, JESKEWITZ, HIXSON, PETERSEN, WOOD, DAVIS, BIES, MURSAU, VOS, PETROWSKI, HINES, STRACHOTA, ALBERS, GRIGSBY, SHERIDAN, SEIDEL, A. WILLIAMS, WASSERMAN, KRUSICK and KREUSER, cosponsored by Senators SULLIVAN, KREITLOW, COWLES, LEHMAN, ROESSLER, HARSDDORF, DARLING, ROBSON, TAYLOR and GROTHMAN. Referred to Committee on Small Business.

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 and
4 insurers and providing a penalty.

Analysis by the Legislative Reference Bureau

This bill requires health care providers, as defined in the bill, to provide health care consumers with certain charge or payment rate information, upon request by and at no cost to the consumers; the information must be updated annually and may not be construed as a legally binding estimate. Under the bill, a health care provider must, within a reasonable period of time after a consumer's request, provide the consumer with the median billed charges (as defined in the bill), assuming no complications, for inpatient or outpatient health care services, diagnostic tests, or procedures provided by the health care provider that the consumer specifies. In addition, upon request, the health care provider must immediately, on site, provide the consumer with all of the following information, as a single document:

1. The median billed charge, assuming no medical complications, for each of 25 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, as specified annually by the Department of Health and Family Services (DHFS). This information must be classified by diagnosis-related groups or all-patient refined diagnosis-related groups, if provided by a hospital for inpatient services; by surgical procedure code, if provided by a hospital for outpatient services or if provided by an ambulatory surgery center;

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by presenting conditions, if provided by a physician; and by a grouping form similar to that for a hospital or a physician, if provided by a health care provider that is not a hospital or a physician.

2. If the health care provider is certified as a provider of Medical Assistance (MA), the MA payment rates for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

3. If the health care provider is certified as a provider of Medicare, the Medicare payment rates for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

4. The average allowable payment from private, third-party payers for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

Under the bill, a violation of these requirements is subject to an administrative forfeiture of up to \$500.

Under the bill, a self-insured health plan of the state or a county, city, village, town, or school district, or an insurer that provides coverage under a health insurance policy, including defined network plans and sickness care plans operated by cooperative associations, must provide to an insured under the health insurance policy or an enrollee under the self-insured health plan a good faith estimate of the median reimbursement that the insurer or self-insured health plan would expect to pay for a specified health care service in the geographic region in which the service will be provided. In addition, the insurer or self-insured health plan must provide to an insured or enrollee a good faith estimate of the insured's or enrollee's total out-of-pocket cost for the specified service. The information must be provided only if the insured or enrollee requests it, and it must be provided at no charge to the insured or enrollee. Before providing any of the information, the insurer or self-insured health plan may require the insured or enrollee to provide the name of the provider providing the service, the facility at which the service will be provided, the date the service will be provided, and the provider's estimate of the charges. However, the insurer or self-insured health plan may not require the insured or enrollee to provide the Current Procedural Terminology code or Current Dental Terminology code for the service as a condition of providing the information. In addition, the bill provides that any good faith estimate provided is not a legally binding estimate.

The bill also requires health care providers to display prominently statements informing health care consumers of the consumers' right to request charge or payment rate information for health care services, diagnostic tests, or procedures from the health care providers or from their insurers.

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:

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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).

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

14 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
15 a village provides health care benefits under its home rule power, or if a town
16 provides health care benefits, to its officers and employees on a self-insured basis,
17 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
18 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87
19 (4) ~~and~~, (5), ~~and~~ (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

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

22 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
23 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
24 632.798, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), ~~and~~ (6), 632.895 (9) to (15),
25 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

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

2 **146.903 Disclosures required of health care providers.** (1) In this
3 section:

4 (a) “All-patient refined diagnosis-related groups” means a system of
5 classifying inpatient hospital discharges that applies to patients of any age and
6 distinguishes among 4 levels of severity of illness within each classification.

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

8 (c) “Clinic” means a place, other than a residence, that is used primarily for the
9 provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and
10 treatment.

11 (d) “Diagnosis-related groups” means a classification of inpatient hospital
12 discharges specified under 42 CFR 412.60.

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

15 (f) “Median billed charge” means the amount that a health care provider
16 charged for a health care service, diagnostic test, or procedure, before any discount
17 or contractual rate applicable to certain patients or payers was applied, during the
18 first 2 calendar quarters of the most recently completed calendar year, as calculated
19 by arranging the charges in that reporting period from highest to lowest and
20 selecting the middle charge in the sequence or, for an even number of charges,
21 selecting the 2 middle charges in the sequence and calculating the average of the 2.

22 (g) “Medical Assistance” means health care benefits provided under subch. IV
23 of ch. 49.

24 (h) “Medicare” means coverage under part A or part B of Title XVIII of the
25 federal Social Security Act, 42 USC 1395 to 1395dd.

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1 (2) Except as provided in sub. (5), a health care provider or the health care
2 provider's designee shall, upon request by and at no cost to a health care consumer,
3 disclose to the consumer all of the following, under the following circumstances:

4 (a) Within a reasonable period of time after the request, the median billed
5 charge, assuming no medical complications, for an inpatient or outpatient health
6 care service, diagnostic test, or procedure that is specified by the consumer and that
7 is provided by the health care provider.

8 (b) Immediately upon request, on the site of the health care provider, as a single
9 document, all of the following:

10 1. The median billed charge, assuming no medical complications, for each of 25
11 health care services, diagnostic tests, or procedures, relevant to the treatment of
12 particular presenting conditions, as specified annually by the department based on
13 claims data under Medical Assistance from the most recently-completed fiscal year.

14 The information under this subdivision shall be classified as follows:

15 a. If provided concerning inpatient services by a hospital, by diagnosis-related
16 groups or all-patient refined diagnosis-related groups.

17 b. If provided concerning outpatient services by a hospital, or if provided by an
18 ambulatory surgery center, by surgical procedure code.

19 c. If provided by a physician, under a classification of physician specialties that
20 is specified by the department, by presenting conditions, including the total charges
21 for codes under the Current Procedural Terminology of the American Medical
22 Association that are most frequently performed as a result of the presenting
23 conditions. "Presenting conditions" under this subd. 1. c. shall be defined by the
24 department after consulting with the Wisconsin Collaborative for Healthcare
25 Quality.

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1 d. If provided by a health care provider other than a hospital or physician, by
2 a grouping form similar to that under subd. 1. a., b., or c. Notwithstanding the
3 requirement under subd. 1. (intro.) that 25 health care services, diagnostic tests, or
4 procedures be disclosed, if the health care provider under this subd. 1. d. performs
5 fewer than 25 health care services, diagnostic tests, or procedures on a regular basis,
6 the health care provider shall indicate that fact and disclose those health care
7 services, diagnostic tests, or procedures that the health care provider performs on a
8 regular basis.

9 2. If the health care provider is certified as a provider of Medical Assistance,
10 the Medical Assistance payment rates for the provider for the health care services,
11 diagnostic tests, or procedures specified in subd. 1.

12 3. If the health care provider is certified as a provider of Medicare, the Medicare
13 payment rates for the provider for the health care services, diagnostic tests, or
14 procedures specified in subd. 1.

15 4. The average allowable payment from private, 3rd-party payers for the
16 health care services, diagnostic tests, or procedures specified in subd. 1.

17 **(3)** Information on charges or payment rates that is provided to a health care
18 consumer under sub. (2) shall be updated annually by the health care provider and
19 may not be construed as a legally binding estimate of the cost to the consumer.

20 **(4)** Except as provided in sub. (5), a health care provider shall prominently
21 display, in the area of the health care provider's practice or facility that is most
22 commonly frequented by health care consumers, a statement informing the
23 consumers that they have the right to request charge or payment rate information
24 for health care services, diagnostic tests, or procedures from the health care provider

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1 or, if the requirements under s. 632.798 (2) (e) are met, all of the following from their
2 insurers or self-insured health plans:

3 (a) A good faith estimate of the median reimbursement that the insurer or
4 self-insured health plan would expect to pay for a specified health care service in the
5 geographic region in which the health care service will be provided.

6 (b) A good faith estimate of the insured's total out-of-pocket cost according to
7 the insured's benefit terms for the specified health care service in the geographic
8 region in which the health care service will be provided.

9 **(5)** This section does not apply to any of the following:

10 (a) A health care provider that practices individually and not in association
11 with another health care provider.

12 (b) Health care providers that are an association of 3 or fewer individual health
13 care providers.

14 **(6)** (a) Whoever violates this section may be required to forfeit not more than
15 \$500 for each violation.

16 (b) The department may directly assess forfeitures provided for under par. (a).
17 If the department determines that a forfeiture should be assessed for a particular
18 violation, the department shall send a notice of assessment to the alleged violator.
19 The notice shall specify the amount of the forfeiture assessed, the violation, and the
20 statute or rule alleged to have been violated, and shall inform the alleged violator of
21 the right to a hearing under par. (c).

22 (c) An alleged violator may contest an assessment of a forfeiture by sending,
23 within 10 days after receipt of notice under par. (b), a written request for a hearing
24 under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1).
25 The administrator of the division may designate a hearing examiner to preside over

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1 the case and recommend a decision to the administrator under s. 227.46. The
2 decision of the administrator of the division shall be the final administrative
3 decision. The division shall commence the hearing within 30 days after receipt of the
4 request for a hearing and shall issue a final decision within 15 days after the close
5 of the hearing. Proceedings before the division are governed by ch. 227. In any
6 petition for judicial review of a decision by the division, the party, other than the
7 petitioner, who was in the proceeding before the division shall be the named
8 respondent.

9 (d) All forfeitures shall be paid to the department within 10 days after receipt
10 of notice of assessment or, if the forfeiture is contested under par. (c), within 10 days
11 after receipt of the final decision after exhaustion of administrative review, unless
12 the final decision is appealed and the order is stayed by court order. The department
13 shall remit all forfeitures paid to the secretary of administration for deposit in the
14 school fund.

15 (e) The attorney general may bring an action in the name of the state to collect
16 any forfeiture imposed under this subsection if the forfeiture has not been paid
17 following the exhaustion of all administrative and judicial reviews. The only issue
18 to be contested in any such action is whether the forfeiture has been paid.

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

21 185.981 (4t) A sickness care plan operated by a cooperative association is
22 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798,
23 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and (5)~~, and (6), 632.895 (10) to (15),
24 and 632.897 (10) and chs. 149 and 155.

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

3 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be
4 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
5 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
6 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, ~~632.798~~, 632.85,
7 632.853, 632.855, 632.87 (2m), (3), (4), ~~and (5)~~, and (6), 632.895 (5) and (9) to (15),
8 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring
9 association shall:

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

11 **609.71 Disclosure of payments.** Limited service health organizations,
12 preferred provider plans, and defined network plans are subject to s. 632.798.

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

14 **632.798 Disclosure of payments. (1) DEFINITIONS.** In this section:

15 (a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

16 (b) "Insured" includes an enrollee under a self-insured health plan and a
17 representative or designee of an insured or enrollee.

18 (c) "Self-insured health plan" means a self-insured health plan of the state or
19 a county, city, village, town, or school district.

20 **(2) PROVIDE INFORMATION.** (a) A self-insured health plan or an insurer that
21 provides coverage under a disability insurance policy shall, at the request of an
22 insured, provide to the insured a good faith estimate of the median reimbursement
23 that the insurer or self-insured health plan would expect to pay for a specified health
24 care service in the geographic region in which the health care service will be
25 provided.

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1 (b) If requested by the insured, the insurer or self-insured health plan under
2 par. (a) shall also provide to the insured a good faith estimate, as of the date of the
3 request, of the insured's total out-of-pocket cost according to the insured's benefit
4 terms for the specified health care service in the geographic region in which the
5 health care service will be provided.

6 (c) An estimate provided by an insurer or self-insured health plan under this
7 section is not a legally binding estimate of the reimbursement or out-of-pocket cost.

8 (d) An insurer or self-insured health plan may not charge an insured for
9 providing the information under this section.

10 (e) 1. Before providing any of the information requested under par. (a) or (b),
11 the insurer or self-insured health plan may require the insured to provide any of the
12 following information:

13 a. The name of the provider providing the service.

14 b. The facility at which the service will be provided.

15 c. The date the service will be provided.

16 d. The provider's estimate of the charge for the service.

17 2. The insurer or self-insured health plan may not require an insured to
18 provide the code for the service under the Current Procedural Terminology of the
19 American Medical Association or under the Current Dental Terminology of the
20 American Dental Association as a condition for providing the information requested
21 under par. (a) or (b).

SECTION 10. Initial applicability.

22 (1) DISCLOSURE OF CHARGES, PAYMENTS, AND OUT-OF-POCKET COSTS. If a disability
23 insurance policy or a governmental self-insured health plan that is in effect on the
24 effective date of this subsection, or a contract or agreement between a provider and
25

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

5 **SECTION 11. Effective date.**

6 (1) This act takes effect on the first day of the 10th month beginning after
7 publication.

8 (END)