2007 DRAFTING REQUEST

Bill

Received: **11/07/2007**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Steve Wieckert (608) 266-3070**

By/Representing: **Matt Seaholm (aide)**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters: **pkahler**

Subject: **Health - miscellaneous**
Insurance - health

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Wieckert@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Health care information disclosure requirements

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	dkennedy 11/07/2007	csicilia 11/07/2007		_____ _____			S&L
/1			nnatzke 11/07/2007	_____ _____	lparisi 11/07/2007	lparisi 11/07/2007	S&L
/2	dkennedy 01/16/2008	csicilia 01/16/2008	jfrantze 01/16/2008	_____ _____	mbarman 01/16/2008	mbarman 01/16/2008	

FE Sent For: "12" @ Intro. 1-24-08

<END>

2007 DRAFTING REQUEST

Bill

Received: **11/07/2007**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Steve Wieckert (608) 266-3070**

By/Representing: **Matt Seaholm (aide)**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters: **pkahler**

Subject: **Health - miscellaneous**
Insurance - health

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Wieckert@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Health care information disclosure requirements

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	dkennedy 11/07/2007	csicilia 11/07/2007		_____ _____			S&L
/1			nnatzke 11/07/2007	_____ _____	lparisi 11/07/2007	lparisi 11/07/2007	S&L
/2	dkennedy 01/16/2008	csicilia 01/16/2008	jfrantze 01/16/2008	_____ _____	mbarman 01/16/2008		

FE Sent For:

<END>

2007 DRAFTING REQUEST

Bill

Received: **11/07/2007**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Steve Wieckert (608) 266-3070**

By/Representing: **Matt Seaholm (aide)**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters: **pkahler**

Subject: **Health - miscellaneous**
Insurance - health

Extra Copies:

Submit via email: **YES**

changed requestor

Requester's email: **Rep.Wieckert@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Health care information disclosure requirements

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	dkennedy 11/07/2007	csicilia 11/07/2007		_____ _____			S&L
/1			nnatzke 11/07/2007	_____ _____	lparisi 11/07/2007	lparisi 11/07/2007	

1/2 gs 1/16/08

1/16 1/16

FE Sent For:

<END>

2007 DRAFTING REQUEST

Bill

Received: **11/07/2007**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Terry Moulton (608) 266-9172**

By/Representing: **Matt Seaholm (aide)**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters: **pkahler**

Subject: **Health - miscellaneous**
Insurance - health

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Moulton@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Health care information disclosure requirements

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	dkennedy 11/07/2007	csicilia 11/07/2007		_____ _____			S&L
/1			nnatzke 11/07/2007	_____ _____	lparisi 11/07/2007	lparisi 11/07/2007	

/2 jg 1/16 08

FE Sent For:

<END>

2007 DRAFTING REQUEST

Bill

Received: **11/07/2007**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Terry Moulton (608) 266-9172**

By/Representing: **Matt Seaholm (aide)**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters: **pkahler**

Subject: **Health - miscellaneous**
Insurance - health

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Moulton@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Health care information disclosure requirements

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	dkennedy 11/07/2007	csicilia 11/07/2007		_____ _____			S&L
/1			nnatzke 11/07/2007	_____ _____	lparisi 11/07/2007		

FE Sent For:

<END>

2007 DRAFTING REQUEST

Bill

Received: **11/07/2007**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Terry Moulton (608) 266-9172**

By/Representing: **Matt Seaholm (aide)**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters: **pkahler**

Subject: **Health - miscellaneous**
Insurance - health

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Moulton@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Health care information disclosure requirements

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	dkennedy	1 gs 11/7 07	nwn 11/7	nwn 11/7			

FE Sent For:

<END>

Kennedy, Debora

To: Seaholm, Matthew
Subject: RE: Co-sponsorship of LRB-3210/1, relating to disclosure of information by health care providers and insurers

Yes, Matt, thank you. We should be able to get that to you today.

From: Seaholm, Matthew
Sent: Wednesday, November 07, 2007 10:35 AM
To: Kennedy, Debora
Subject: FW: Co-sponsorship of LRB-3210/1, relating to disclosure of information by health care providers and insurers

Hi Debora,

Rep. Moulton is looking to draft a companion bill to LRB 3210. Would you be able to do that for us?

Thanks,
Matt Seaholm
Office of Rep. Moulton
6-9172

From: Sen.Sullivan
Sent: Tuesday, October 23, 2007 12:39 PM
To: *Legislative Assembly Democrats; *Legislative Assembly Republicans; *Legislative Senate Democrats; *Legislative Senate Republicans
Subject: Co-sponsorship of LRB-3210/1, relating to disclosure of information by health care providers and insurers

Date: October 23, 2007

To: All Legislators

From: Senator Jim Sullivan

RE: Co-sponsorship of LRB-3210/1, relating to disclosure of information by health care providers and insurers

Rising health care costs are a real, everyday problem for Wisconsin families. As premiums rise, more and more employers are turning towards high deductible plans placing more of the financial responsibility on the consumer. Yet the ability of consumers to make informed decisions is limited by the lack of available information and a complex pricing system.

I am introducing legislation to provide consumers with information about the cost of their health care. The legislation will:

- Require health care providers to disclose, upon request and at no cost to the consumer, the usual and customary charge for a specific service.

- Require insurance companies to provide consumers, upon request and at no cost to the consumer, with its allowable payment for a specific service with a specific provider. In addition, the insurance company will be required to provide the consumer with his or her estimated out-of-pocket costs for the specific service.

- Require health care providers to maintain a price list for their fifty most frequently performed services. In order to ensure this information is understandable and relevant it will be broken down into usual and customary charges, Medical Assistance payment rates, and average allowable payments from third-party payers.

This legislation uses the definition of 'health care provider' currently in the statutes, including doctors and hospitals as well as chiropractors, dentists, physical therapists, optometrists, dieticians, and other licensed health care providers.

This legislation grants an exemption for small providers (3 or fewer) and includes a six month delayed effective date.

This legislation empowers people to be better consumers of health care, and I urge you to support it with your co-sponsorship. Please contact Nicole in my office by **Monday, November 5th at 5:00 p.m.** if you would like to co-sponsor.

Analysis by the Legislative Reference Bureau

This bill requires health care providers, as defined and limited 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 the request, provide the consumer with the usual and customary charges, 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 usual and customary charge, assuming no medical complications, for each of the 50 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, that the health care provider most frequently performs. This information must be classified in the form of diagnosis–related groups, if provided by a hospital; in the form of presenting conditions, if provided by a physician; and in 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, as specified on the Web site of the Department of Health and Family Services, for the provider's 50 most frequently performed health care services, diagnostic tests, or procedures.

3. The average allowable payment from private, third party payers for the provider's 50 most frequently performed health care services, diagnostic tests, or procedures.

4. The average of the charges and payment rates for each health care service, diagnostic test, or procedure specified in 1. to 3., above.

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 reimbursement that the insurer or self−insured health plan would expect to pay a specified provider for a specified health care service. 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 provided by the specified provider. 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. 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.

<< File: LRB 3210.pdf >>

TODAY

3424/1

2007 – 2008 LEGISLATURE

LRB–~~3210/1~~
DAK&PJK:cjs:~~pg~~

stays

2007 BILL

companion; no changes made

Regn cat

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 146.903, 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers and insurers.

Analysis by the Legislative Reference Bureau

This bill requires health care providers, as defined and limited 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 the request, provide the consumer with the usual and customary charges, 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 usual and customary charge, assuming no medical complications, for each of the 50 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, that the health care provider most frequently performs. This information must be classified in the form of diagnosis–related groups, if provided by a hospital; in the form of presenting conditions, if provided by a physician; and in 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, as specified on the Web site of the Department of Health and Family Services, for the provider's 50 most frequently performed health care services, diagnostic tests, or procedures.

3. The average allowable payment from private, third party payers for the provider's 50 most frequently performed health care services, diagnostic tests, or procedures.

4. The average of the charges and payment rates for each health care service, diagnostic test, or procedure specified in 1. to 3., above.

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 reimbursement that the insurer or self–insured health plan would expect to pay a specified provider for a specified health care service. 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 provided by the specified provider. 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. 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:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.895 (5m) and (8) to (14), and 632.896.

SECTION 2. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (14).

SECTION 3. 66.0137 (4) of the statutes is amended to read:

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

SECTION 4. 120.13 (2) (g) of the statutes is amended to read:

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

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

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

(a) "Ambulatory surgery center" has the meaning given in 42 CFR 416.2.

(b) "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.

(c) "Diagnosis–related groups" means a classification of inpatient hospital discharges specified under 42 CFR 412.60.

(d) "Health care provider" has the meaning given in s. 146.81 (1) and includes a clinic and an ambulatory surgery center.

(e) "Medical Assistance" means health care benefits provided under subch. IV of ch. 49.

(f) "Usual and customary charge" means the amount that a health care provider usually and customarily charges for a health care service, diagnostic test, or procedure, before any discount or contractual rate applicable to certain patients or payers is applied.

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

(a) Within a reasonable period of time after the request, the usual and customary charges, assuming no medical complications, for an inpatient or outpatient health care service, diagnostic test, or procedure that is specified by the consumer and that is provided by the health care provider.

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

1. The usual and customary charge, assuming no medical complications, for each of the 50 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, that the health care provider most frequently performs. The information under this subdivision shall be classified as follows:

a. If provided concerning inpatient or outpatient services by a hospital, in the form of diagnosis–related groups.

b. If provided by a physician, in the form of presenting conditions, including the total charges for codes under the Current Procedural Terminology of the American Medical Association that are most frequently performed as a result of the presenting conditions.

c. If provided by a health care provider other than a hospital or physician, in a grouping form similar to that under subd. 1. a. or b. Notwithstanding the requirement under subd. 1. (intro.) that 50 health care services, diagnostic tests, or procedures be disclosed, if the health care provider under this subd. 1. c. performs fewer than 50 health care services, diagnostic tests, or procedures on a regular basis, the health care provider shall indicate that fact and disclose those health care services, diagnostic tests, or procedures that the health care provider performs on a regular basis.

2. If the health care provider is certified as a provider of Medical Assistance, the Medical Assistance payment rates, as specified on the Web site of the department, for the provider for the health care services, diagnostic tests, or procedures specified in subd. 1.

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

4. The average of the charges and payment rates specified in subd. 1., 2., and 3. for each health care service, diagnostic test, or procedure specified in subd. 1.

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

(4) Except as provided in sub. (5), a health care provider shall prominently display, in the area of the health care provider's practice or facility that is most

commonly frequented by health care consumers, a statement informing the consumers that they have the right to request charge or payment rate information for health care services, diagnostic tests, or procedures from the health care provider or, under s. 632.798, all of the following from their insurers or self–insured health plans:

(a) A good faith estimate of the reimbursement that the insurer or self–insured health plan would expect to pay a specified provider for a specified health care service.

(b) A good faith estimate of the insured's total out–of–pocket cost for the specified health care service provided by the specified provider.

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

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

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

SECTION 6. 185.981 (4t) of the statutes is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (10) to (14), and 632.897 (10) and chs. 149 and 155.

SECTION 7. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,

632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (5) and (9) to (14), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

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

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

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

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

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

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

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

(2) PROVIDE INFORMATION. (a) A self–insured health plan or an insurer that provides coverage under a disability insurance policy shall, at the request of an insured, provide to the insured a good faith estimate of the reimbursement that the insurer or self–insured health plan would expect to pay a specified provider for a specified health care service.

(b) If requested by the insured, the insurer or self–insured health plan under par. (a) shall also provide to the insured a good faith estimate of the insured's total out–of–pocket cost for the specified health care service provided by the specified provider.

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

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

SECTION 10. Initial applicability.

(1) DISCLOSURE OF PAYMENTS AND OUT–OF–POCKET COSTS. If a disability insurance policy or a governmental self–insured health plan that is in effect on the effective date of this subsection contains a provision that is inconsistent with the treatment of section 40.51 (8) or (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.71, or 632.798 of the statutes, the treatment of section 40.51 (8) or (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.71, or 632.798 of the statutes first applies to that disability insurance policy or governmental self–insured health plan on the date on which it is modified, extended, or renewed.

SECTION 11. Effective date.

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

(END)

Duerst, Christina

From: Seaholm, Matthew
Sent: Wednesday, November 07, 2007 4:03 PM
To: LRB.Legal
Subject: Draft Review: LRB 07-3424/1 Topic: Health care information disclosure requirements

Please Jacket LRB 07-3424/1 for the ASSEMBLY.

Kennedy, Debora

To: Seaholm, Matthew
Subject: RE: LRB 3424

Thanks, Matt.

From: Seaholm, Matthew
Sent: Friday, November 30, 2007 2:00 PM
To: Kennedy, Debora
Subject: LRB 3424

Hi Debora,

Rep Wieckert has taken the lead on LRB 3424. His office has asked me to transfer authorship over to them. If you could make that change, that would be great.

Thanks,

Matt
Matt Seaholm
Office of Rep. Terry Moulton
Wisconsin's 68th Assembly District
(608) 266-9172

Kennedy, Debora

From: Becher, Scott
Sent: Friday, January 04, 2008 11:03 AM
To: Kennedy, Debora
Subject: FW: Changes to Transparency Bill

Attachments: Scott Becher 1.2.08.doc; Revisionn to SB 337.doc

---

From: Becher, Scott
Sent: Wednesday, January 02, 2008 2:41 PM
To: Sweet, Richard
Subject: Changes to Transparency Bill

Dick-

Can you review these changes to Senate Bill 337. I am looking for any insight that you can give.

Thanks,

Scott

From: Hudzinski, Nicole
Sent: Wednesday, January 02, 2008 1:54 PM
To: Becher, Scott
Subject: Transparency

Hi Scott, attached are the changes. Please let me know if your boss has concerns with any of these changes.

Nicole


Scott Becher 1.2.08.doc (40 KB...


Revisionn to SB 337.doc (50 KB...

TO: Scott Becher
FROM: Nicole Hudzinski
DATE: January 2, 2008
RE: Revisions to SB 337, Disclosure of Health Care Costs

Recommendation: Standardize the 'top 50 list', have DHFS set it each year based on Medicaid claims data from the year before (Medicaid data is the only data the state has). Also reduce the list to a number lower than 50, but have it broken out by specialty.

For example, DHFS would establish separate lists for primary care providers, optometrists, neurologists, dermatologists, and other specialty groups.

Everyone I have talked to agrees the list should be standardized. DHFS is currently producing an example list of me of the top 25 services and procedures performed by primary care physicians last year.

We have requested the drafters make these changes.

Recommendation: Remove the Medicaid payment rates column on the 'top 50 list'.

Provider groups are concerned that consumers will misinterpret this information and will think it is the 'real' cost of providing care.

Consumer groups and business groups have requesting keeping it in. They believe it will help demonstrate cost shifting.

We have requested the drafters keep the Medicaid column in and also add a Medicare column. (Medicare has more out-of-pocket costs than Medicaid)

Recommendation: Remove the 4th column in the 'top 50 list' (the column that averages the usual and customary, Medicaid, and 3rd party payers)

Many stakeholders have questioned the usefulness of this column.

We have requested the drafters remove this column. This was added based solely on the Minnesota legislation.

Recommendation: Require WHA or some other entity (possibly the state) to be the central repository for all components of a procedure and accumulate the 'episode of care' price estimate.

Under the current draft a consumer would need to call multiple providers groups to obtain a price estimate for a procedure that involves multiple providers. For example, if you're having knee replacement surgery, you would have to call the doctor, the hospital, the anesthesiologist, and the radiologist to get each of their price estimates (they all bill separately and do not know what each other is charging.)

We are working with WHA on a compromise solution.

Recommendation: Require patients to obtain CPT codes from provider before health plan provides good faith estimate and out-of-pocket costs.

The HMO's requested this. They want to provide an exact estimate to their enrollees, and the only way they can do that is to require their enrollees to provide them with an itemized list of CPT codes that will be performed. They would then calculate an estimate of benefits (EOB) on the front end and the back end.

We are not making this change. We are worried this would be too much work for the provider and the consumer. Instead, as currently drafted, the health plan will be required to provide an estimate based on the provider estimate (i.e. Provider group says knee replacement costs $30,000; health plan says we have a 30% discount so we'll only pay them $21,000, and you have 10% coinsurance so you'll owe $2,100).

Recommendation: Require health plans to provide 'median reimbursements' to enrollees instead of 'reimbursements'.

The HMOs have requested this be changed to 'median reimbursement'. We have requested the drafters make this change.

Recommendation: Specify elective services only.

A few stakeholders have requested the bill specify elective procedures only. We are not making this change.

Recommendation: Add state oversight methods and penalties for noncompliance.

We are currently working with the drafters to build in penalties for noncompliance.

Recommendation: Remove exemption for small provider groups (currently drafted the bill exempts independent providers and providers in an association of 3 or fewer individual health care providers.)

Provider groups appreciate this component, but business and consumer groups have requested it be removed.

We are not removing this exemption.

Recommendation: Change delayed effective date to 12 months (currently drafted the bill has a 6 month delayed effective date)

The HMOs requested this. We have asked the drafters to change it to 9 months.

Revisions to SB 337

Location	Revision
Page 3, line 23	Change "Diagnosis-related groups" to "All-patient refined diagnosis-related groups" meaning a classification of inpatient hospital discharges developed by 3MCorporation designed to apply to patients of all ages and to distinguish among four severity of illness levels within each classification. Term used in s. 146.903 (2) (b) 1.a Distinguishes APR-DRGs from standard (Medicare) DRGs.
Page 4, lines 5-8	Replace "usual and customary charge" with "median billed charge" and define it as "the median amount that a health care provider has charged for the specified service or procedure, before any discount or contractual rate applicable to certain patients or payers is applied, in the most recent 12 months"
Starting on page 4, line 18	Instead of the using the top 50 health care services, diagnostic tests or procedures, we want to standardize the list statewide based on specialty and have DHFS set the list annually based on Medicaid claims data (volume) the year before. For example, DHFS would set a list of the top 25 services performed by primary care physicians, and that is what they would report on for that year. DHFS would also set a list for optometrists, neurologists, dermatologists, etc. Some list may be less than 25 services or procedures.
Page 4, lines 18-24	Change to "the median billed charge, assuming no medical complications, for each of the 25 health care services, diagnostic tests, or procedures as set annually by DHFS. The information under this subdivision shall be classified as follows: a. If provided concerning inpatient services by a hospital, in the form of diagnosis-related groups or all-patient refined diagnosis-related groups. b. If provided concerning outpatient services by a hospitals, by surgical procedure code. c. If provided by an ambulatory surgery center, by surgical procedure code.
Page 4, lines 18-22	A few stakeholders have commented this is confusing and read literally, seems to require the top 50 services related to each of an unknown number of presenting conditions, for example the top 50 services related to leg pain, the top 50 services related to back pain, etc.
Page 4, line 23-24	WHA tells me DRG's are not used to categorize hospital outpatient services.
Page 5, lines 13-16	Note: providers have questioned what "Medical Assistance payment rates, as specified on the Web site of the department" means.
Page 5, insert after line 16	Add a requirement that the list include Medicare payment rates (in addition to Medicaid required under #2)

Page 5, lines 17-18	WHA has requested language be added to allow for the "percentage of charges collected by the provider from private 3rd party payers, as derived from the data collected pursuant to s. 153.21 (2) Wis Admin Code. Can you check what that means? We would like to allow providers to report the average aggregate percentage discount provided to commercial insurers, but in a dollar amount.
Page 5, line 19-20	Remove #4 (the column that averages all the other columns)
Page 7, lines 14-18	We want to be sure this language does not require enrollees to obtain an itemized list of CPTs prior to obtaining an estimate. (see INS 3.60). We do, however, want to require the enrollee to provide the health plans with 1.) the name of the provider; 2.) the facility where the service or procedure will be provided; 3.) the date the procedure will be done; and 4.) the providers estimate of charges.
Page 7, line 16	We want to allow health plans to provide median reimbursements, but we want them calculated based on geographic areas (again see INS 3.60)
Page 7, lines 19-22	Change to "If requested by the insured and after the insured provides all necessary information, the insurer or self-insured health plan under par. (a) shall also provide to the insured as of the date of the request a good faith estimate of the insured's total out-of-pocket cost according to the insured benefit terms for the specified health care service provided by the specified provider, assuming no complications or modifications to the treatment plan."
Page 8, section 10	The health plans say this section only applies to the contract between the health plan and the enrollee, not the contract between the health plan and the provider. We need this to apply to both contracts.
Page 8, line 13	Change delayed effective date to 9 months
Unknown	Should we define "provider good faith estimate" and "health plan good faith estimate" since there are different expectations of what a good faith estimate is?
Unknown	We need to add state oversight/penalties, both on the insurance side and on the provider side. What do you suggest?
Unknown	We are working with WHA to find a way for the hospitals to report the total cumulative average for a procedure (i.e. instead of only reporting the hospital fee associated with knee replacement, they would report the hospital fee plus the doctors fee plus the anesthesiologist fee plus the radiologist fees). If we go in this direction, we would want the vendor specialties to report the information to WHA and then WHA would analyze and report it publicly.
Unknown	Health plan question: what if service or procedure requires review regarding if it's medically necessary?

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-3424/1
DAK&PJK:cjs:nwn

2007 BILL

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 146.903, 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers and insurers.

Analysis by the Legislative Reference Bureau

This bill requires health care providers, as defined and limited 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 the request, provide the consumer with the usual and customary charges, 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 usual and customary charge, assuming no medical complications, for each of the 50 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, that the health care provider most frequently performs. This information must be classified in the form of diagnosis-related groups, if provided by a hospital; in the form of presenting conditions, if provided by a physician; and in 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, as specified on the Web site of the Department of Health and Family Services, for the provider's 50 most frequently performed health care services, diagnostic tests, or procedures.

3. The average allowable payment from private, third party payers for the provider's 50 most frequently performed health care services, diagnostic tests, or procedures.

4. The average of the charges and payment rates for each health care service, diagnostic test, or procedure specified in 1. to 3., above.

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 reimbursement that the insurer or self-insured health plan would expect to pay a specified provider for a specified health care service. 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 provided by the specified provider. 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. 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:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.895 (5m) and (8) to (14), and 632.896.

SECTION 2. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (14).

SECTION 3. 66.0137 (4) of the statutes is amended to read:

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

SECTION 4. 120.13 (2) (g) of the statutes is amended to read:

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

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

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

(a) "Ambulatory surgery center" has the meaning given in 42 CFR 416.2.

(b) "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.

(c) "Diagnosis-related groups" means a classification of inpatient hospital discharges specified under 42 CFR 412.60.

(d) "Health care provider" has the meaning given in s. 146.81 (1) and includes a clinic and an ambulatory surgery center.

(e) "Medical Assistance" means health care benefits provided under subch. IV of ch. 49.

(f) "Usual and customary charge" means the amount that a health care provider usually and customarily charges for a health care service, diagnostic test, or procedure, before any discount or contractual rate applicable to certain patients or payers is applied.

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

(a) Within a reasonable period of time after the request, the usual and customary charges, assuming no medical complications, for an inpatient or outpatient health care service, diagnostic test, or procedure that is specified by the consumer and that is provided by the health care provider.

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

1. The usual and customary charge, assuming no medical complications, for each of the 50 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, that the health care provider most frequently performs. The information under this subdivision shall be classified as follows:

a. If provided concerning inpatient or outpatient services by a hospital, in the form of diagnosis-related groups.

b. If provided by a physician, in the form of presenting conditions, including the total charges for codes under the Current Procedural Terminology of the American Medical Association that are most frequently performed as a result of the presenting conditions.

c. If provided by a health care provider other than a hospital or physician, in a grouping form similar to that under subd. 1. a. or b. Notwithstanding the requirement under subd. 1. (intro.) that 50 health care services, diagnostic tests, or procedures be disclosed, if the health care provider under this subd. 1. c. performs fewer than 50 health care services, diagnostic tests, or procedures on a regular basis, the health care provider shall indicate that fact and disclose those health care services, diagnostic tests, or procedures that the health care provider performs on a regular basis.

2. If the health care provider is certified as a provider of Medical Assistance, the Medical Assistance payment rates, as specified on the Web site of the department, for the provider for the health care services, diagnostic tests, or procedures specified in subd. 1.

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

4. The average of the charges and payment rates specified in subd. 1., 2., and 3. for each health care service, diagnostic test, or procedure specified in subd. 1.

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

(4) Except as provided in sub. (5), a health care provider shall prominently display, in the area of the health care provider's practice or facility that is most

commonly frequented by health care consumers, a statement informing the consumers that they have the right to request charge or payment rate information for health care services, diagnostic tests, or procedures from the health care provider or, under s. 632.798, all of the following from their insurers or self-insured health plans:

(a) A good faith estimate of the reimbursement that the insurer or self-insured health plan would expect to pay a specified provider for a specified health care service.

(b) A good faith estimate of the insured's total out-of-pocket cost for the specified health care service provided by the specified provider.

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

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

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

SECTION 6. 185.981 (4t) of the statutes is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (10) to (14), and 632.897 (10) and chs. 149 and 155.

SECTION 7. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,

632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (5) and (9) to (14), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

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

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

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

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

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

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

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

(2) PROVIDE INFORMATION. (a) A self-insured health plan or an insurer that provides coverage under a disability insurance policy shall, at the request of an insured, provide to the insured a good faith estimate of the reimbursement that the insurer or self-insured health plan would expect to pay a specified provider for a specified health care service.

(b) If requested by the insured, the insurer or self-insured health plan under par. (a) shall also provide to the insured a good faith estimate of the insured's total out-of-pocket cost for the specified health care service provided by the specified provider.

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

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

SECTION 10. Initial applicability.

(1) DISCLOSURE OF PAYMENTS AND OUT-OF-POCKET COSTS. If a disability insurance policy or a governmental self-insured health plan that is in effect on the effective date of this subsection contains a provision that is inconsistent with the treatment of section 40.51 (8) or (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.71, or 632.798 of the statutes, the treatment of section 40.51 (8) or (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.71, or 632.798 of the statutes first applies to that disability insurance policy or governmental self-insured health plan on the date on which it is modified, extended, or renewed.

SECTION 11. Effective date.

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

(END)

Kennedy, Debora

From: Hudzinski, Nicole
Sent: Monday, January 14, 2008 10:08 AM
To: Kennedy, Debora
Cc: Becher, Scott
Subject: SB 337 sub amendment

Debora, after further discussion with Scott, please draft the Assembly companion as a slash 2 so that it matches the language included in the sub you send me on Wednesday. Basically, we'd like the Assembly version that gets introduced to match our Senate version as amended by the sub amendment. We're confident that the sub you send me on Wednesday will include the changes as requested.

Also, to reiterate, please send the sub to Senator Sullivan's email and to my email: Nicole.hudzinski@legis.wi.gov

Thanks Debora and please call me if you have questions.

Nicole

2007 – 2008 LEGISLATURE

LRBs0205/2
DAK&PJK:cjs:rs

SENATE SUBSTITUTE AMENDMENT ,
TO 2007 SENATE BILL 337

AN ACT *to amend* 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and *to create* 146.903, 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers and insurers and providing a penalty.

Analysis by the Legislative Reference Bureau

This substitute amendment requires health care providers, as defined in the substitute amendment, 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 substitute amendment, 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 substitute amendment), 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; 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 ~~substitute amendment~~, a violation of these requirements is subject to an administrative forfeiture of up to $500.

Under the ~~substitute amendment~~, 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 ~~substitute amendment~~ provides that any good faith estimate provided is not a legally binding estimate.

The ~~substitute amendment~~ 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.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

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

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

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

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

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

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

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

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

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

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

(b) "Ambulatory surgery center" has the meaning given in 42 CFR 416.2.

(c) "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.

(d) "Diagnosis–related groups" means a classification of inpatient hospital discharges specified under 42 CFR 412.60.

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

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

(g) "Medical Assistance" means health care benefits provided under subch. IV of ch. 49.

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

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

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

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

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 based on claims data under Medical Assistance from the most recently–completed fiscal year. The information under this subdivision shall be classified as follows:

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

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

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

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

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

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

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

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

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

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

(a) 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 health care service will be provided.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) PROVIDE INFORMATION. (a) A self–insured health plan or an insurer that provides coverage under a disability insurance policy shall, at the request of an insured, provide to the insured 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 health care service will be provided.

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

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

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

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

a. The name of the provider providing the service.

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

c. The date the service will be provided.

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

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

SECTION 10. Initial applicability.

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

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

SECTION 11. Effective date.

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

(END)

Barman, Mike

From: Barman, Mike
Sent: Thursday, January 17, 2008 8:41 AM
To: Rep.Wieckert; Becher, Scott
Subject: LRB 07-3424/2 (attached - requested by Scott)

Attachments: 07-3424/2

07-34242.pdf (40 KB)

Mike Barman (Senior Program Assistant)
State of Wisconsin - Legislative Reference Bureau
Legal Section - Front Office
1 East Main Street, Suite 200, Madison, WI 53703
(608) 266-3561 / mike.barman@legis.wisconsin.gov