2007 DRAFTING REQUEST

Assembly Substitute Amendment (ASA-AB729)

Received: **02/08/2008**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

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

By/Representing: **Jessica Karls (Leg. Council)**

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: **robin.ryan@legis.wisconsin.gov**

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 02/08/2008	csicilia 02/11/2008		_____ _____			
/1			nnatzke 02/11/2008	_____ _____	mbarman 02/11/2008	mbarman 02/11/2008	

FE Sent For:

<END>

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Extra Copies: laura.rose@legis.wisconsin.gov

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/?	dkennedy	/1 gjs 2/11 08	nwn 2/11	nwn/jf 2/11			

FE Sent For:

<END>

2/7/06

From Rep. Wiecket

Redraft s0229/1:

p. 9, l. 19 – remove "not"

(Probably requires deletion of subdivisions w/in par. (d))

Instructions from LRB s0229

will be transferred

to this file (last steps

we loved not return them –

needed new LRB number)

RESEARCH APPENDIX - Draft Transfer/Copy Request Form

- Atty's please complete this form and give to Mike Barman

(Request Made By: DAK) (Date: 2 / 8 / 08)

○ ☞ Please transfer the drafting file for

2005 LRB _____ to the drafting file

for **2007 LRB** _____

Done MB

☞ The final version of the 2005 draft and the final Request Sheet will copied on yellow paper, and returned to the original 2005 drafting file. A new cover sheet will be created/included listing the new location of the drafting file's "guts".

☞ For research purposes, because the 2005 draft was incorporated into a 2007 draft, the complete drafting file will be transferred, as a separate appendix, to the new 2007 drafting file. This request form will be inserted into the "guts" of the 2007 draft. If introduced, the appendix will be scanned/added to the electronic drafting file folder.

--OR --

○ ☞ Please copy the drafting file for

2007 LRB S0229 / 2 (include the version) and place it in the

drafting file for **2007 LRB** S0265

☞ For research purposes, because the original 2007 draft was incorporated into another 2007 draft, the original drafting file will be copied on yellow paper (darkened/auto centered/reduced to 90%) and added, as a separate appendix, to the new 2007 drafting file. This request form will be inserted into the "guts" of the new 2007 draft. If introduced the appendix will be scanned/added to the electronic drafting file folder.

☞ The original drafting file will then returned, intact, to its folder and filed. For future reference, a copy of the transfer/copy request form will also be added to the "guts" of the original draft.

MONDAY

State of Wisconsin
2007 - 2008 LEGISLATURE

s0226s1

LRBs0229/1
DAK&PJK:cjs:nwn

stays

Rush

ASSEMBLY SUBSTITUTE AMENDMENT ,

TO 2007 ASSEMBLY BILL (LRB-3424/2) 729

(in 2-8)

full history

Regen Cat

patients of the health care providers

patient's

patients

patient

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 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 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

and the appropriate Current Procedural Terminology code of the American Medical Association (CPT code).

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.

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 insured's or enrollee's total out-of-pocket cost for a specified health care service in the geographic region in which the service will be provided. 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 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 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.

patient of the health care provider

(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 an individual ~~health care consumer~~, for the ~~consumer's~~ patient's own use, disclose to the ~~consumer~~ all of the following, under the following circumstances:

patient

(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, all of the following:

(1) 1. The median billed charge, assuming no medical complications.

(2) 2. The appropriate code ~~for the service, test, or procedure~~ under the Current Procedural Terminology of the American Medical Association.

(b) Immediately upon request, on the site of the health care provider, 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 paragraph shall be classified as follows:

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

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

3. 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 subdivision shall be defined by the department after consulting with the Wisconsin Collaborative for Healthcare Quality.

4. If provided by a health care provider other than a hospital or physician, by a grouping form similar to that under subd. 1., 2., or 3. Notwithstanding the requirement under par. (b) (intro.) that 25 health care services, diagnostic tests, or procedures be disclosed, if the health care provider under this subdivision 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.

(3) Information on charges that is provided to a ~~health care consumer~~ patient 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~~ patient.

(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~~ patients, a statement informing the ~~consumers~~ patients that they have the right to request charge information for health care services, diagnostic tests, or procedures from the health care provider or, if the requirements under s. 632.798 (2) (d) are met, a good faith estimate, from their insurers or self-insured health plans, 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 out-of-pocket costs. 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 out-of-pocket costs. (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 ESTIMATE. (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, as of the date of the request and assuming no medical complications or modifications to the treatment plan, of the insured's total out-of-pocket cost according to the insured's benefit terms for a specified health care service in the geographic region in which the health care service will be provided.

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

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

(d) 1. Before providing the information requested under par. (a), 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).

SECTION 10. Initial applicability.

(1) DISCLOSURE OF CHARGES 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.

LPS: fix components → **SECTION 11. Effective date.** → s

(1) This act takes effect on the first day of the 10th month beginning after publication except as follows:

(END)

CS

(1) # FORFEITURE. The treatment of section 146.903(6) of the statutes takes effect on the first day of the 20th month beginning after publication.

Barman, Mike

From: Barman, Mike
Sent: Monday, February 11, 2008 3:18 PM
To: Rose, Laura
Subject: LRB 07s0265/1 (attached - from DAK)

Attachments: 07s0265/1

07s02651.pdf (37 KB)