

2007 SENATE BILL 337

November 21, 2007 – Introduced by Senators SULLIVAN, KREITLOW, LEHMAN, COWLES, ROESSLER, DARLING, ROBSON and TAYLOR, cosponsored by Representatives WIECKERT, MOULTON, MUSSER, ALBERS, GRIGSBY, SHERIDAN, SEIDEL, A. WILLIAMS, SHILLING, WOOD, JESKEWITZ, WASSERMAN, F. LASEE, KRUSICK, HRAYCHUCK and KREUSER. Referred to Committee on Health, Human Services, Insurance, and Job Creation.

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.

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

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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:

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

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

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

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1 40.51 **(8m)** Every health care coverage plan offered by the group insurance
2 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
3 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (14).

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

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

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

12 120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss.
13 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
14 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.895 (9) to (14),
15 632.896, and 767.513 (4).

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

17 **146.903 Disclosures required of health care providers. (1)** In this
18 section:

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

20 (b) “Clinic” means a place, other than a residence, that is used primarily for the
21 provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and
22 treatment.

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

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

3 (e) “Medical Assistance” means health care benefits provided under subch. IV
4 of ch. 49.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 185.981 (4t) A sickness care plan operated by a cooperative association is
18 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798,
19 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (10) to (14), and
20 632.897 (10) and chs. 149 and 155.

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

22 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be
23 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
24 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
25 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,

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1 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (5) and (9) to (14), 632.896,
2 and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association
3 shall:

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

5 **609.71 Disclosure of payments.** Limited service health organizations,
6 preferred provider plans, and defined network plans are subject to s. 632.798.

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

8 **632.798 Disclosure of payments. (1) DEFINITIONS.** In this section:

9 (a) “Disability insurance policy” has the meaning given in s. 632.895 (1) (a).

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

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

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

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

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

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

SECTION 10. Initial applicability.

3
4 (1) DISCLOSURE OF PAYMENTS AND OUT-OF-POCKET COSTS. If a disability insurance
5 policy or a governmental self-insured health plan that is in effect on the effective
6 date of this subsection contains a provision that is inconsistent with the treatment
7 of section 40.51 (8) or (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1)
8 (intro.), 609.71, or 632.798 of the statutes, the treatment of section 40.51 (8) or (8m),
9 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.71, or 632.798 of the
10 statutes first applies to that disability insurance policy or governmental self-insured
11 health plan on the date on which it is modified, extended, or renewed.

SECTION 11. Effective date.

12
13 (1) This act takes effect on the first day of the 7th month beginning after
14 publication.

15 (END)