2007 DRAFTING REQUEST

Bill

Received: **09/20/2007**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Jim Sullivan (608) 266-2512**

By/Representing: **Nicole Hudzinski (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: **Sen.Sullivan@legis.wisconsin.gov**

Carbon copy (CC:) to: **robin.ryan@legis.wisconsin.gov**
Laura.Rose@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 09/28/2007 pkahler 10/01/2007	csicilia 10/02/2007		_______ _______ _______ _______			
/P1			nnatzke 10/02/2007	_______ _______	sbasford 10/02/2007		
/P2	dkennedy	csicilia	jfrantze	_______	sbasford		S&L

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	10/08/2007 pkahler 10/08/2007	10/16/2007	10/16/2007	_______ _______ _______	10/16/2007		
/1	dkennedy 10/16/2007 pkahler 10/16/2007	csicilia 10/22/2007	nnatzke 10/22/2007	_______ _______ _______ _______	sbasford 10/22/2007	sbasford 10/24/2007	

FE Sent For: "/1" @ intro. 11-21-07 **<END>**

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/1	dkennedy 10/16/2007 pkahler 10/16/2007	csicilia 10/22/2007	nnatzke 10/22/2007		sbasford 10/22/2007		

per Nicole

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/1 cjs 10/22/07

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/P2 cjs 10/16/07 jd 10/16 jd 10/16 NN 10/16

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/?	dkennedy			______ ______			

FE Sent For:

<END>

Sen. Sullivan

Kennedy, Debora

From: Hudzinski, Nicole
Sent: Wednesday, September 19, 2007 9:30 AM
To: Kennedy, Debora
Subject: MN disclosure laws

Below is the MN legislation that we're interested in modeling WI legislation after. The only real change we want to this (as of now) is:

The MN legislation requires a provider give a consumer a good faith estimate of the reimbursement the provider expects to receive from the health plan in which the consumer is enrolled.

We would prefer to draft it that a provider is required to give the consumer their usual and customary charges (retail) cost for a specific services. Instead of placing the burden on the provider to interpret the type of insurance the consumer has, we would like to put the responsibility on the consumer to then call their insurance company to find out how much they are going to pay and how much the consumer will pay out of pocket.

Does that make sense?

Also, at the end of this email is a revision MN made to their law this year. I haven't read through it yet, but I will by tomorrow.

Thanks,
Nicole

62J.81 ◀DISCLOSURE▶ OF PAYMENTS FOR HEALTH CARE SERVICES.

Subdivision 1. **Required ◀disclosure▶ of estimated payment.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, provide that consumer with a good faith estimate of the reimbursement the provider expects to receive from the health plan company in which the consumer is enrolled. Health plan companies must allow contracted providers, or their designee, to release this information. A good faith estimate must also be made available at the request of a consumer who is not enrolled in a health plan company. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the ◀cost▶ of services.

X See below — ultimate charge to the consumer

(b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee or the enrollee's designee, provide that enrollee with a good faith estimate of the reimbursement the health plan company would expect to pay to a specified provider within the network for a health care service specified by the enrollee. If requested by the enrollee, the health plan company shall also provide to the enrollee a good faith estimate of the enrollee's out-of-pocket ◀cost▶ for the health care service. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the reimbursement or out-of-pocket ◀cost▶.

* PJK

Subd. 2. **Applicability.** For purposes of this section, "consumer" does not include a medical assistance, MinnesotaCare, or general assistance medical care enrollee, for services covered under those programs.

62J.052 PROVIDER COST DISCLOSURE.

Subdivision 1. **Health care providers.** (a) Each health care provider, as defined by section 62J.03, subdivision 8, except hospitals and outpatient surgical centers subject to the requirements of section 62J.823, shall provide the following information:

(1) the average allowable payment from private third-party payers for the 50 services or procedures most commonly performed;

(2) the average payment rates for those services and procedures for medical assistance;

(3) the average charge for those services and procedures for individuals who have no applicable private or public coverage; and
(4) the average charge for those services and procedures, including all patients.
(b) This information shall be updated annually and be readily available at no cost to the public on site.

Subd. 2. **Pharmacies.** (a) Each pharmacy, as defined in section 151.01, subdivision 2, shall provide the following information to a patient upon request:
(1) the pharmacy's own usual and customary ◀price▶ for a prescription drug;
(2) a record, including all transactions on record with the pharmacy both past and present, of all co-payments and other cost-sharing paid to the pharmacy by the patient for up to two years; and
(3) the total amount of all co-payments and other cost-sharing paid to the pharmacy by the patient over the previous two years.
(b) The information required under paragraph (a) must be readily available at no cost to the patient.

Minnesota Chapter 147

Price Disclosure

(Article 15, Section 9)

This original price disclosure in Minnesota law was enacted in 2004. In 2006, the disclosure section of law changed to apply to health plans, hospitals, and providers. In 2007, the below section of law was amended to reflect suggestions from different groups, including the MN Hospital Association as well as the MN Council of Health Plans. The "cost to the consumer" change was an effort to eliminate an attempt in the market, as charges to the consumer or providers to obtain the data will no longer be permitted. The new "allowable payment" language addresses the providers concern that co-pays and deductibles are not a part of the reimbursed amount from health plans, as that is the patient responsibility.

427.5 Sec. 9. Minnesota Statutes 2006, section 62J.81, subdivision 1, is amended to read:
427.6 Subdivision 1. **Required disclosure of estimated payment.** (a) A health care
427.7 provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed
427.8 to by that designee, shall, at the request of a consumer, and at no cost to the consumer
427.9 or the consumer's employer, provide that consumer with a good faith estimate of the
427.10 ~~reimbursement~~ allowable payment the provider ~~expects to receive from the health plan~~
427.11 ~~company in which the consumer is enrolled~~ has agreed to accept from the consumer's
427.12 health plan company for the services specified by the consumer, specifying the amount of
427.13 the allowable payment due from the health plan company. Health plan companies must
427.14 allow contracted providers, or their designee, to release this information. ~~A good faith~~
427.15 ~~estimate must also be made available at the request of a consumer who is not enrolled in~~
427.16 ~~a health plan company.~~ If a consumer has no applicable public or private coverage, the
427.17 health care provider must give the consumer, and at no cost to the consumer, a good faith
427.18 estimate of the average allowable reimbursement the provider accepts as payment from
427.19 private third-party payers for the services specified by the consumer and the estimated
427.20 amount the noncovered consumer will be required to pay. Payment information provided
427.21 by a provider, or by the provider's designee as agreed to by that designee, to a patient
427.22 pursuant to this subdivision does not constitute a legally binding estimate of the allowable

427.23 charge for or cost to the consumer of services.
427.24 (b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at
427.25 the request of an enrollee or the enrollee's designee, provide that enrollee with a good
427.26 faith estimate of the ~~reimbursement~~ allowable amount the health plan company ~~would~~
427.27 ~~expect to pay to~~ has contracted for with a specified provider within the network as total
427.28 payment for a health care service specified by the enrollee and the portion of the allowable
427.29 amount due from the enrollee and the enrollee's out-of-pocket costs. ~~If requested by the~~
427.30 ~~enrollee, the health plan company shall also provide to the enrollee a good faith estimate~~
427.31 ~~of the enrollee's out-of-pocket cost for the health care service.~~ An estimate provided to
427.32 an enrollee under this paragraph is not a legally binding estimate of the ~~reimbursement~~
427.33 allowable amount or enrollee's out-of-pocket cost.
427.34 **EFFECTIVE DATE.** This section is effective August 1, 2007.

Kennedy, Debora

From: Hudzinski, Nicole
Sent: Wednesday, September 26, 2007 4:56 PM
To: Kennedy, Debora
Subject: RE: MN transparency law

We don't want to exempt any MDs. I know that.

From: Kennedy, Debora
Sent: Wednesday, September 26, 2007 3:18 PM
To: Hudzinski, Nicole
Subject: RE: MN transparency law

I know that not all MDs in Wisconsin are MA certified providers. And, yes, if you defined "health care provider" as MN has done, uncertified MDs would be exempt.

From: Hudzinski, Nicole
Sent: Wednesday, September 26, 2007 3:01 PM
To: Kennedy, Debora
Subject: RE: MN transparency law

Do you know if all MDs in Wisconsin are certified providers of MA? I assume some docs don't take MA patients. Would this language exempt them from the disclosure requirement?

From: Kennedy, Debora
Sent: Wednesday, September 26, 2007 2:33 PM
To: Hudzinski, Nicole
Subject: RE: MN transparency law

Yes, except that the MN definition requires that a health care provider (other than a nursing home, which is excepted) be "eligible for reimbursement under the medical assistance program..."--the equivalent in Wisconsin is a requirement that the health care provider be a certified provider of MA. I assume that some of the professions under the definition of "health care provider" under s. 146.81, stats., would not qualify as certified MA providers--for instance, bodyworkers, marriage and family therapists, athletic trainers, and probably acupuncturists.

From: Hudzinski, Nicole
Sent: Wednesday, September 26, 2007 2:16 PM
To: Kennedy, Debora; Rose, Laura
Subject: MN transparency law

Hi Ladies,

So I stopped at St. Mary's in Duluth Monday on my way home and wasn't able to get a price list. I asked the check-in staff at the clinic in the hospital and she had no idea what I was talking about. She even called a financial advisor for the clinic that assists patients with price questions and he said they don't have anything like that. Strange.

Below is the definition the MN statute uses for "provider". As you can see it is very inclusive, and I think we should start with the similar language, which I think allows us to go with the definition already in WI statute, right?

Subd. 8. **Provider or health care provider.** "Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to

directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

9/20/07 Nicole Hudzinski, Laura Rose, Alexis MacDonald

✓ That health care provider's usual + customary charge

(PJK) Insurers required to provide good-faith estimate of reimbursement

625.052 Def of health care provider – Nicole will
✓ look at 146.81 (1)

✓ 2003 ~~4358~~ 4538/1

(NOTE) ✓ Total cost for a procedure (episode of care), including hospitalization, etc., assuming no complications

✓ Info to be provided {immediately / upon request} on site

✓ 50 most commonly performed procedures: use CPTs or DRGs

✓ services relevant to treatment of a particular condition

✓ Pharmacies: Disclose that prices change frequently
Info to be provided immediately upon request

✓ Delayed eff date: 6 mo.

LRB
Wisconsin Legislative Reference Bureau

STATE OF WISCONSIN – **LEGISLATIVE REFERENCE BUREAU**

LRB Research (608–266–0341) Library (608–266–7040) Legal (608–266–3561) **LRB**

Health plans have to provide info at no cost

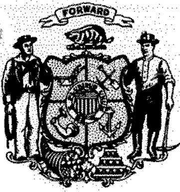
? MA – fee-for-service rates : LR. check what Minnesota does.

✓ Keep in exception for hospitals + outpt surg centers

Try to complete by Mon after next

Copy to Laura Rose

LRB Wisconsin Legislative Reference Bureau



State of Wisconsin
2007 - 2008 LEGISLATURE

D-NOTE

LRB-3210/P1
DAK&PJK:...:...

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

1 AN ACT ...; **relating to:** disclosure of information by health care providers,
2 pharmacies, and insurers.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided for a subsequent version.

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

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

4 **146.903 Disclosures required of health care providers. (1)** In this
5 section:

6 (a) "Health care provider" means any of the following:

7 1. A chiropractor licensed under ch. 446.

8 2. A dentist licensed under ch. 447.

9 3. A registered nurse licensed under s. 441.06; an advanced practice nurse
10 certified under s. 441.16 (2); or a nurse-midwife licensed under s. 441.15.

1 4. An optometrist licensed under ch. 449.

2 5. A physician or physician assistant licensed under subch. II of ch. 448.

3 6. A physical therapist licensed under subch. III of ch. 448.

4 7. A podiatrist licensed under subch. IV of ch. 448.

5 8. A psychologist licensed under ch. 455.

****NOTE: This listing of health care providers is one that I arbitrarily chose; it is not inclusive of all the providers listed under s. 146.81 (1), stats. Is it useful for your purposes?

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

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

11 **(2)** A health care provider or the health care provider's designee shall
12 immediately, upon request by a patient, disclose to the patient on site all of the
13 following:

****NOTE: Do you want to require that this information be provided at no cost to the patient?

14 (a) The usual and customary charges, assuming no medical complications, for
15 outpatient services provided by the health care provider that are classified as
16 evaluation or management services in the American Medical Association's Current
17 Procedural Terminology, and for which the Current Procedural Terminology
18 identifies a code.

19 (b) The usual and customary charge, assuming no medical complications, for
20 each of the 50 diagnostic tests or procedures relevant to the treatment of a particular
21 condition that the health care provider most frequently performs.

****NOTE: My notes indicate that you were interested in the "total cost" for a procedure, including hospitalization. However, you have also chosen not to include

hospitals or ambulatory surgery centers as health care providers; I think it is probable that a health care provider, as defined in this bill so far, would not necessarily have access to average or typical hospital charges.

1 (c) If the health care provider is certified as a provider of Medical Assistance,
2 the payment rate for the provider under Medical Assistance for the services, tests,
3 or procedures specified in pars. (a) and (b).

****NOTE: This provision is problematic, as we discussed, because a health care provider who is associated with a managed care program that has a contracted–for capitated rate for services to MA recipients may not have a specific payment rate for a specific service. DHFS has, on its website, MA payment rates; I presume that these are fee–for–service rates that are not necessary relevant to a program of managed care.

4 (d) The average charge for the services, tests, or procedures specified in pars.
5 (a) and (b) for individuals who have no applicable private or public coverage.
6 (e) The average of the average charges specified in pars. (a), (b), (c) and (d).
7 **(3)** Information on charges or payment rates that is provided to a patient under
8 sub. (2) may not be construed as a legally binding estimate of the cost to the patient.
9 **SECTION 2.** 450.115 of the statutes is created to read:
10 **450.115 Price disclosure.** A pharmacy shall immediately, upon receipt of a
11 request for retail prescription drug pricing information from an individual, disclose
12 to the individual all of the following:
13 **(1)** The pharmacy's current retail price for the prescription drug for which
14 information is requested.
15 **(2)** The fact that a pharmacy's retail prices for prescription drugs frequently
16 change.

****NOTE: Do you want to require that this information be provided at no cost to the individual?

17 **SECTION 3. Effective date.**

Medical Assistance
for each service, test, or procedure specified in pars. (a) and (b)
ily
health care
and payment rates
Insert 3–8
Insert 3–16

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

D-NOTE

INSERT 1-3

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.

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 95, 115, 155; 2001 a. 16, 38, 104; 2003 a. 33; 2005 a. 194.

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).

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 95, 115, 155; 2001 a. 16, 38, 104; 2003 a. 33; 2005 a. 194.

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).

History: 1999 a. 9, 115; 1999 a. 150 ss. 34, 303 to 306; Stats. 1999 s. 66.0137; 1999 a. 186 s. 63; 2001 a. 16, 30; 2005 a. 194; 2005 a. 443 s. 265.

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).

History: 1973 c. 94, 290; 1975 c. 115, 321; 1977 c. 206, 211, 418, 429; 1979 c. 20, 202, 221, 301, 355; 1981 c. 96, 314, 335; 1983 a. 27, 193, 207, 339, 370, 518, 538; 1985 a. 29 ss. 1725e to 1726m, 1731; 1985 a. 101, 135, 211; 1985 a. 218 ss. 12, 13, 22; 1985 a. 332; 1987 a. 88, 187; 1989 a. 31, 201, 336, 359; 1991 a. 39, 226, 269; 1993 a. 16, 27,

Ins 1-3 contd 2 of 2

284, 334, 399, 450, 481, 491; 1995 a. 27 ss. 4024, 9126 (19), 9145 (1); 1995 a. 29, 32, 33, 65, 75, 225, 235, 289, 439; 1997 a. 27, 155, 164, 191, 237, 335; 1999 a. 9, 19, 73, 83, 115, 128; 1999 a. 150 s. 672; 1999 a. 186; 2001 a. 38, 98, 103, 105; 2003 a. 254; 2005 a. 22, 194, 290, 346; 2005 a. 443 s. 265; s. 13.93 (1) (b).

(END OF INSERT 1-3)

INSERT 3-8

1 **SECTION 5.** 185.981 (4t) of the statutes is amended to read:

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

History: 1971 c. 40 s. 93; 1971 c. 307 s. 118; 1975 c. 98; 1975 c. 223 s. 28; 1975 c. 224 s. 146; 1975 c. 421; 1981 c. 39 s. 22; 1981 c. 205; 1981 c. 391 s. 210; 1985 a. 29; 1985 a. 30 s. 42; 1987 a. 27 ss. 1917e, 3202 (47) (a); 1987 a. 312 s. 17; 1989 a. 121, 129, 200, 201, 336; 1991 a. 39, 123, 269; 1993 a. 27, 450, 481; 1995 a. 27, 118, 289; 1997 a. 27, 155, 237; 1999 a. 95, 115; 2003 a. 321; 2005 a. 194.

6 **SECTION 6.** 185.983 (1) (intro.) of the statutes is amended to read:

7 185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be
8 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
9 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
10 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,
11 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (5) and (9) to (14), 632.896,
12 and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association
13 shall:

History: 1975 c. 98; 1975 c. 224 s. 146; 1975 c. 352; 1975 c. 422 s. 163; 1977 c. 339; 1979 c. 89; 1981 c. 20; 1981 c. 39 s. 22; 1981 c. 82; 1981 c. 391 s. 210; 1983 a. 189 s. 329 (25); 1983 a. 396; 1985 a. 29 ss. 2060d to 2060r, 3202 (30); 1987 a. 27, 325; 1989 a. 23, 31, 129, 200, 201, 336, 359; 1991 a. 39, 189, 250, 269, 315; 1993 a. 450, 481, 482; 1995 a. 289; 1997 a. 27, 155, 237; 1999 a. 95, 115; 2003 a. 321; 2005 a. 194.

(END OF INSERT 3-8)

INSERT 3-16 1 of 3

14 **SECTION 7.** 609.30 (3) of the statutes is created to read:

15 609.30 **(3)** PLAN MAY NOT PROHIBIT DISCLOSURE OF CHARGES OR PRICES. A defined
16 network plan, preferred provider plan, or limited service health organization may
17 not, by contract or otherwise, prohibit a participating provider from disclosing to

Ins 3-16 contd 2013

1 anyone who asks the information under s. 146.903 regarding charges or payment
2 rates or the information under s. 450.115 regarding retail prices.
3 **SECTION 8.** 609.71 of the statutes is created to read:
4 **609.71 Disclosure of payments.** Limited service health organizations,
5 preferred provider plans, and defined network plans are subject to s. 632.798.
6 **SECTION 9.** 632.798 of the statutes is created to read:
7 **632.798 Disclosure of payments. (1)** DEFINITIONS. In this section:
8 (a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).
9 (b) "Insured" includes an enrollee under a self-insured health plan and a
10 representative or designee of an insured or enrollee.
11 (c) "Self-insured health plan" means a self-insured health plan of the state or
12 a county, city, village, town, or school district.
13 **(2)** PROVIDE INFORMATION. (a) A self-insured health plan or an insurer that
14 provides coverage under a disability insurance policy shall, at the request of an
15 insured, provide to the insured a good faith estimate of the reimbursement that the
16 insurer or self-insured health plan would expect to pay a specified provider for a
17 specified health care service.
18 (b) If requested by the insured, the insurer or self-insured health plan under
19 par. (a) shall also provide to the insured a good faith estimate of the insured's
20 total out-of-pocket cost for the specified health care service.
21 (c) An estimate provided by an insurer or self-insured health plan under this
22 section is not a legally binding estimate of the reimbursement or out-of-pocket cost.
23 **SECTION 10. Initial applicability.**
24 (1) DISCOLSURE OF CHARGES AND PRICES. If a contract or agreement between a
25 provider and a defined network plan, preferred provider plan, or limited service

Insert 3-16 contd 3 of 3

1 health organization that is in effect on the effective date of this subsection contains
2 a provision that is inconsistent with section 609.30 (3) of the statutes, section 609.30
3 (3) of the statutes first applies to that contract or agreement on the date on which it
4 is modified, extended, or renewed.

5 (2) DISCLOSURE OF PAYMENTS AND OUT-OF-POCKET COSTS. If a disability insurance
6 policy or a governmental self-insured health plan that is in effect on the effective
7 date of this subsection contains a provision that is inconsistent with section 632.798
8 of the statutes, section 632.798 of the statutes first applies to that disability
9 insurance policy or governmental self-insured health plan on the date on which it
10 is modified, extended, or renewed.

(END OF INSERT 3-16)

40.51 (8) or (8m), 66.0137 (4), 120.13 (2) (g),
185.981 (4t), 185.983 (1) (intro.), 609.71,

or

Drafter's Note
from the
Legislative Reference Bureau

LRB-3210/?dn
DAK&PJK:...:...

To Senator Sullivan:

This bill is in preliminary form, to provide you with ample opportunity to review it prior to introduction, and because numerous issues arose in drafting. I have interspersed statutory provisions in the bill with ****NOTES where particular issues need clarification.

Please let me know if I may provide you with further assistance concerning this draft.

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
E-mail: debora.kennedy@legis.wisconsin.gov

The Minnesota law requires a "health plan company" to provide enrollees, upon request, with information about how much the company would expect to reimburse a provider "within the network" for a specified health care service. I'm not sure what is comparable to a "health plan company" in Wisconsin. However, I have imposed the requirement on all insurers, which would include both defined network plans and indemnity insurers that pay any provider on a fee-for-service basis. I have not limited the requirement to payments to providers "within the network."

Depending on its arrangement with the providers in its network, a defined network plan, such as an HMO, might not be able to specify how much it will reimburse a provider for a service. The provider may receive a salary and not be paid by each service provided.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

(¶) Do you want to specify that an insurer must provide this information at no charge?

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3210/P1dn
DAK&PJK:cjs:nwn

October 2, 2007

To Senator Sullivan:

This bill is in preliminary form, to provide you with ample opportunity to review it prior to introduction, and because numerous issues arose in drafting. I have interspersed statutory provisions in the bill with ****NOTES where particular issues need clarification.

Please let me know if I may provide you with further assistance concerning this draft.

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Depending on its arrangement with the providers in its network, a defined network plan, such as an HMO, might not be able to specify how much it will reimburse a provider for a service. The provider may receive a salary and not be paid by each service provided.

Do you want to specify that an insurer must provide this information at no charge?

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

-3210

Kennedy, Debora

From: Hudzinski, Nicole
Sent: Tuesday, October 02, 2007 7:25 PM
To: Kennedy, Debora
Cc: Hudzinski, Nicole
Subject: RE: disclosure bill

Attachments: transparency bill prelim draft.doc

transparency bill prelim draft...

Attached are my responses/comments. Please let me know if you have any questions. I'll be in Milwaukee on Thursday in meetings with my boss, but please feel free to call me on my cell phone if you have question. I might not be able to answer when you call, but I'll call you back as soon as I can.

I hope the format I used is helpful. I haven't been on the drafting side before so this is all new to me.

Thanks for your help,
Nicole
Cell 608-225-4042

-----Original Message-----
From: Kennedy, Debora
Sent: Tue 10/2/2007 3:19 PM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

E-mail would be just fine,, at this point, if it's okay with you.

From: Hudzinski, Nicole
Sent: Tuesday, October 02, 2007 3:06 PM
To: Kennedy, Debora; Kahler, Pam
Subject: disclosure bill

How do you prefer for me to answer your questions? Via email or in person?

1.) Question about comparable definition to "health plan company".

We would like this to include any entity that provides health insurance in the state of Wisconsin. Would the insurance commissioner's office have a definition for this? The Wisconsin Health Plans Association (http://wihealthplans.org) includes many of the organizations I'm thinking of, like Blue Cross Blue Shield, Human, DeanCare, etc.

I'm not familiar with indemnity insurers, but from how you described them I think they should be included. It sounds like the definition you used is good.

2.) Do you want to specify that an insurer must provide this information at no charge?

Yes, we want to require all information provided in this legislation is provided at no cost to the consumer.

3.) Definition of "health care provider".

We would like to use the broad definition currently in statute 146.81(1). This definition includes inpatient health care facilities, which includes hospitals, nursing homes, county homes, county mental health hospitals, or other places licensed or approved by the department… We could also use something more general, like the MN definition, which is defined as "a person or organization other than a nursing home that provides health care or medical care services within MN for a fee and is eligible for reimbursement under the medical assistance program…" We would not, however, want to include the eligible for reimbursement under medical assistance however. I'm not sure why MN excludes nursing homes, but we want to start with including them and we can take them out if necessary.

4.) 146.903(2), lines 10-12

Can we use the word consumer instead of patient? (the person calling may be a potential patient, but not a patient yet)

The only information we want to be immediately available on site is the price listing, similar to MN's 62J.052, for the 50 most common services. This is a requirement for both clinics and hospitals. The specific procedure cost information, similar to MN 62J.81, should be provided within a reasonable time period, but we'd prefer to defer to the providers to establish their own process.

5.) 146.903(2)(a), lines 13-17

If I'm reading this correct, this is the section modeled after MN statute 62J.81(a). If that's correct, this information is only provided if the consumer calls and requests the information. It should include inpatient and outpatient services, and is a requirement

on all providers as defined above in "health care provider", including hospitals and ambulatory surgery centers.

CPT's: Explain

I'm not familiar with services "that are classified as evaluation or management services in the AMA's current procedural terminology, and for which the current procedural terminology identifies a code." What is this part about?

6.) 146.903(2)(b)-(e), lines 18-8

If I'm reading this correct, this is the section modeled off of MN statute 62J.052. This section should include all health care providers, including hospitals and ambulatory surgery centers. To ensure we get the "total cost" of a procedure (i.e. ear infection, heart attack, etc.), I'm told we need to use DRGs for hospitals and CPT codes for physicians. Do you think the language you've used gets at the "total cost"? We don't want it to be a price listing for x-rays and blood tests which is what I understand MN's law to have done.

This is the section that should be immediately available on site, at the request of the consumer, and it should be updated annually. And again, at no cost to the consumer.

If I'm reading this correctly, none of these, (b)-(e), have anything to do with (a). They're separate, like MN's legislation.

The way I'm reading this, (b) will be the usual and customary charge, which is similar to what the uninsured have (unless they're low income and receive a discount from the provider). This would match MN 62J.052(3).

(c) is the medical assistance component, similar to MN 62J.052(2), and I think we decided this would be the fee-for-service rate. I know it's already posted by DHFS, but we think it would be useful to have all these together (average insured cost, uninsured cost, medical assistance cost, and average of the three). Does that address your concern?

(d) seems to reiterate prices for the uninsured, which I believe are what we're requiring in section (b) with the usual and customary charges. I think this section instead should be similar to MN 62J.052(1), the average allowable payment from private third-party payers.

(e) seems to be modeled after MN 62J.052(4), which is the average cost of (b)-(e). In other words, the average payment they receive for an ear infection when you factor in private payers, government payers, and uninsured payers. It does not include average payments for procedures not on the top 50 list.

Should it ?

7.) Section 6 and 7

I don't understand what these sections say.

Xrays

8.) Section 8

We would like to remove the pharmacy section. We think we have our hands full with the other parts.

9.) Section 9 *take out*

We're not asking providers to disclose discounted rates (only requiring them to provide usual and customary rates or average discounted/third-party payments) so is this section necessary?

10.) Section 10 *just defined network plans*

Does this section include all insurers, including the self-insured? Did we address this above in question/comment #1?

11.) Section 11

(a) I'm not familiar with "disability insurance policy". I looked at the definition in the statutes and it sounds necessary, but can you please explain more about what this is?

(b) do we need to include an enrollee of a limited service health organization, preferred provider plan, or defined network plan in the definition of "insured". We want everyone who has any kind of health insurance to be able to call their insurance provider and get an estimate of how much the insurance company will pay a specific provider for a specific procedure and how much the consumer will be responsible for in out-of-pocket costs (co-payments, co-insurance, deductibles, etc.)

"insured" has regular meaning and includes other added ones

(c) what about self-insured businesses? We do want to require them to provide the same information the insurance company would be required to provide. *ERISA problem*

Do we need to include enrollee of a limited service health organization, preferred provider plan, or defined network plan under part (2), provide information or is this already covered since you include a disability insurance policy? I'm confused by this part. *no*

(b), line 12, please add "at a specified provider". Insurers will only be required to provide an estimate for a *specific procedure* with a *specific provider*. The enrollee will have to provide both those pieces of information. *ok*

12.) Section 12

I understand this section to basically say if a provider or provider network are in the middle of a contract period when this legislation is enacted, they are required to

but only if an inconsistent term

comply not at the effective date, but instead upon the negotiation of their next contact. Is that correct?

13.) Additions to the legislation

Please add a requirement that providers post in their facility, somewhere that is in view of the consumer, that they have the right to request price information from the provider and from their insurance company. Please word that however you think is best. — ?

Please build in an exemption for small providers, which if isn't currently defined in the statutes somewhere, by boss would like to define as having three (3) or fewer providers. ?

med. clinics, ambulatory surgery centers associated with 3 or fewer ~~MD's, clinics, dentists~~ individual health care providers – apply to 146.903

STATE OF WISCONSIN – **LEGISLATIVE REFERENCE BUREAU**

LRB Research (608–266–0341) Library (608–266–7040) Legal (608–266–3561) **LRB**

10/5/07 Mtg. w/ Nicole Hudzinski, PJK, DAK

✓ (1) Def. of "hc provider" 146.81(1) – make sure medical clinic + amb. surg. center is included

(2) ✓ (2)(b) – in form of CPT's + DRG's

✓ (2)(d) – as specified in DHFS website

(c) – Top 50 ~~as~~ average allowable payment by private-third party payers

(b) (c) + (d) are U+C [usual customary], MA FFS [fee for service], Insurance (average allowable ~~third party~~)

(e) = average of (b), (c), + (d)

50 top DRG's CPT's

✓ (3) 50 most common – shd. be immediately available on site of provider (at facility)

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU

LRB

Research (608-266-0341) Library (608-266-7040) Legal (608-266-3561)

LRB

10/8/07 From Nicole:

A. Info re (1) 50 services, tests, or procedures; (2) MA info; (3) average allowable payment info; + average of 1-3 should all be on same document + provided immediately on site

B. 1-3 above shd. all include DRG's + hospitals CPT's ⇒ physicians