State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-3210/~~P1~~ P2
DAK&PJK:cjs:~~nwn~~

D-NOTE

r/m is num stays

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

(in 10-8 SOON)

internal refs

REGENERATE

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, 450.115, 609.30 (3), 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers, ~~pharmacies,~~ and insurers.

Analysis by the Legislative Reference Bureau

INSERT ANALYSIS

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:

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:

INSERT 2-19

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

has the meaning given in s. 146.81 (1) and includes a clinic and an ambulatory surgery center

1. A chiropractor licensed under ch. 446.

2. A dentist licensed under ch. 447.

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

4. An optometrist licensed under ch. 449.

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

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

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

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?

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

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

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

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

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

(b) The usual and customary charge, assuming no medical complications, for each of the 50 diagnostic tests or procedures relevant to the treatment of a particular 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.

(c) If the health care provider is certified as a provider of Medical Assistance, the Medical Assistance payment rate for the provider for the services, tests, 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 necessarily relevant to a program of managed care.

(d) The average charge for the services, tests, or procedures specified in pars. (a) and (b) for individuals who have no applicable private or public health care coverage.

(e) The average of the charges and payment rates specified in pars. (a), (b), (c) and (d) for each service, test, or procedure specified in pars. (a) and (b).

(3) Information on charges or payment rates that is provided to a patient under sub. (2) may not be construed as a legally binding estimate of the cost to the patient.

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. 450.115 of the statutes is created to read:

450.115 Price disclosure. A pharmacy shall immediately, upon receipt of a request for retail prescription drug pricing information from an individual, disclose to the individual all of the following:

(1) The pharmacy's current retail price for the prescription drug for which information is requested.

(2) The fact that a pharmacy's retail prices for prescription drugs frequently change.

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

SECTION 9. 609.30 (3) of the statutes is created to read:

609.30 **(3)** PLAN MAY NOT PROHIBIT DISCLOSURE OF CHARGES OR PRICES. A defined network plan, preferred provider plan, or limited service health organization may not, by contract or otherwise, prohibit a participating provider from disclosing to anyone who asks the information under s. 146.903 regarding charges or payment rates or the information under s. 450.115 regarding retail prices.

SECTION 10. 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 11. 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.

(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.

SECTION 12. Initial applicability.

(1) DISCLOSURE OF CHARGES AND PRICES. If a contract or agreement between a provider and a defined network plan, preferred provider plan, or limited service health organization that is in effect on the effective date of this subsection contains a provision that is inconsistent with section 609.30 (3) of the statutes, section 609.30 (3) of the statutes first applies to that contract or agreement on the date on which it is modified, extended, or renewed.

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

the treatment of

632.798 of the statutes, 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 13. Effective date.

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

(END)

D-NOTE

INSERT ANALYSIS

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 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 for inpatient or outpatient health care services, diagnostic tests, or procedures provided by the health care provider that the consumer specifies. In addition, on 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 a particular condition that the health care provider most frequently performs.

2. If the health care provider is certified as a provider of Medical Assistance (MA), the MA payment rates, as specified on the website of the Department of Health and Family Services, for the provider for the provider's 50 most frequently performed health care services, tests, or procedures.

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

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

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.

INSERT 2-19

(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.

concerning inpatient services and

INSERT 3-20

not The information under this subdivision shall be classified in the form of diagnosis-related groups, if provided by a hospital, or in the form of a code under the Current Procedural Terminology of the American Medical Association, if provided by a physician.

INSERT 4-10

(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 from their insurers~~.

or, under s. 632.798, all of the following from their insurers or self-insured health plans:

(5) This section does not apply to ~~health care providers that are an association of 3 or fewer individual health care providers~~.

any of the following:

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

not (b)

not (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.

not (b) A good faith estimate of the insured's total out-of-pocket cost for the specified health service provided by the specified provider.

INSERT A-2

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.

(END OF INSERT A-2)

INSERT 6-12

provided by the specified provider

(END OF INSERT 6-12)

INSERT 6-14

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

(END OF INSERT 6-14)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3210/P2dn
DAK&PJK:cjs:nwn

3 Days

To Senator Sullivan:

This bill is again provided to you in preliminary form, to ensure that you have ample opportunity to review it and make sure that it complies with your intent.

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

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3210/P2dn
DAK&PJK:cjs:jf

October 16, 2007

To Senator Sullivan:

This bill is again provided to you in preliminary form, to ensure that you have ample opportunity to review it and make sure that it complies with your intent.

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

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

Kennedy, Debora

To: Hudzinski, Nicole
Subject: RE: disclosure bill

Yes.

From: Hudzinski, Nicole
Sent: Tuesday, October 16, 2007 2:45 PM
To: Kennedy, Debora
Subject: RE: disclosure bill

Thanks Debora. I sent some hand written changes over via a page.

Regarding question 3, I think we should use the same terminology throughout. Is that OK?

From: Kennedy, Debora
Sent: Tuesday, October 16, 2007 2:38 PM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

1. We define terms that are used frequently and have a specific meaning. We do not use examples in defining, if at all possible, because it's somewhat uncertain what a court will do with the examples; that is, a court may narrow an interpretation to the examples specified or may interpret the defined term broadly. The term "health care service, diagnostic test, or procedure" would be difficult to define very specifically and yet retain the breadth that you seem to want.
2. Yes; the page 4, line 4 reference should be (5).
3. Do you want the term "health care service, diagnostic test, or procedure" to be used in s. 632.798, as well as s. 146.903?
4. Our FAX number is 264-6948.

From: Hudzinski, Nicole
Sent: Tuesday, October 16, 2007 1:26 PM
To: Kennedy, Debora
Subject: RE: disclosure bill

This is a very good draft. Below are my comments/questions:

1.) How do you decide what to define in the bill? Do you think we need to define "health care service, diagnostic test, or procedure"? To make it clear this should be reported in the form of something that makes sense to the consumer, like "knee replacement" or "cesarean delivery" or "broken arm"?
2.) On page 4, line 4, should that reference (5) instead of (4)? Small provider groups (3 or fewer) are exempt from all requirements in this bill, not just the requirement to post that the information is available. They are exempt from all of section 5(2), (3) and (4).
3.) I like the use of "health care service, diagnostic test, or procedure" and I think we should use that language in all sections. (Some sections only say "health care service" or "health service") Can you please add "diagnostic test or procedure" to all places that mention it?

That's all I have for now. I'll make specific language changes on the document and fax it over to you. What's your fax?

Thanks,
Nicole

From: Kennedy, Debora
Sent: Tuesday, October 16, 2007 10:26 AM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

According to our records, it has been submitted to you.

From: Hudzinski, Nicole
Sent: Tuesday, October 16, 2007 10:19 AM
To: Kennedy, Debora
Subject: RE: disclosure bill

Is it possible to get an estimate of when a new draft will be ready?

From: Kennedy, Debora
Sent: Friday, October 12, 2007 12:08 PM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

I believe that it was redrafted Monday or Tuesday, but the editors and typists have been pretty busy since.

From: Hudzinski, Nicole
Sent: Friday, October 12, 2007 12:07 PM
To: Kennedy, Debora
Subject: disclosure bill

Hi Debra, I just wanted to check in and see how it was going with the redraft? I'm sure you're busy working on the Gov's compromise budget and I completely understand, but I just wanted to check in.

Have a good weekend,
Nicole

2007 – 2008 LEGISLATURE

LRB–3210/P2
DAK&PJK:cjs:jf

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

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.

assuming no complications,

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 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 for inpatient or outpatient health care services, diagnostic tests, or procedures provided by the health care provider that the consumer specifies. In addition, upon ~~on~~ 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 conditions, that the health care provider most frequently performs.

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~~ for the provider's 50 most frequently performed health care services, tests, or procedures.

diagnostic

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

4. The average of the charges and payment rates for each health care service, 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.

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).

no comma

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.

should we define "health care service"? "diagnostic test" "procedure"

(f) "Usual and customary charge" means the amount that a health care provider usually and customarily charges for a service, before any discount or contractual rate applicable to certain patients or payers is applied. should this say (5)?

(2) Except as provided in sub. (4), 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 conditions, that the health care provider most frequently performs. The information under this subdivision shall be classified in the form of diagnosis–related groups, if provided concerning inpatient services and by a hospital, or in the form of a code under the Current Procedural Terminology of the American Medical Association, if provided by a physician.

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) 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, diagnostic test or procedure.

(b) A good faith estimate of the insured's total out–of–pocket cost for the specified health care service, diagnostic test or procedure 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, diagnostic test, or procedure.

(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. diagnostic test, or procedure

(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: Friday, October 19, 2007 4:31 PM
To: Kennedy, Debora
Subject: RE: disclosure bill

Hi Debora, I thought it would be helpful to put in one spot the changes we need made to draft 3210/P2. If you're able to make these changes Monday morning, that's fantastic. If not, please send me an introducible draft as is and we'll make the changes later.

Page 4, line 4 should read sub. (5) instead of sub. (4)

Page 4, lines 11-19 should read something like:

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 most frequent health care services, diagnostic tests, or procedures, relevant to the treatment of a particular presented condition. The information under this subdivision shall be classified in the form of diagnosis-related groups, if provided concerning inpatient services and conducted by a hospital, or in the form of presenting conditions, which shall include the total cost of current procedural terminologies (CPTs) of the American Medical Association most frequently performed as the result of the presenting condition, if provided by a physician. For other health care providers, the information under this subdivision shall be classified in a similar grouping form that corresponds to the health care providers most frequently requested services and shall be limited to services performed on a regular basis. (Note: I'm trying to get at the fact that some providers, like chiros and dentists, probably don't have 50 services to list)

Page 5, between lines 5 and 6? Add a section about how the list should be updated annually.

Thanks,
Nicole

From: Kennedy, Debora
Sent: Friday, October 19, 2007 10:29 AM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

I'm sorry; I would be the person to make the changes. If I'm unable to do the redraft as you want, we will send you an introducible draft on Monday.

From: Hudzinski, Nicole
Sent: Friday, October 19, 2007 10:27 AM
To: Kennedy, Debora
Subject: RE: disclosure bill

My boss wants to put something out for co-sponsorship on Monday. Is there anyone else that can make these changes? We need a draft ready by Monday, even if it isn't perfect. If not, can you prepare a draft with the current CPT language that we can send out Monday and then we'll amend it after it's introduced to reflect these changes.

From: Kennedy, Debora
Sent: Friday, October 19, 2007 9:47 AM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

Thank you, Nicole; I will let you know if I have questions. I will be out of the office part of today, so likely will be unable to work on this until Monday or so.

From: Hudzinski, Nicole
Sent: Friday, October 19, 2007 9:19 AM
To: Kennedy, Debora
Subject: RE: disclosure bill

Good morning Debora,

The feedback I'm getting from providers is that the language we have for physicians, using CPT's, won't get us the information we're looking for. I'm told CPT's will get us x-rays, blood tests, and other itemized procedures, which isn't what we want. We want things like sprained ankle, soar throat, ear infection, etc., and unfortunately I'm told there isn't an agreed upon terminology for grouping this sort of thing for physicians. We have it right with hospitals; DRGs group the many tests and procedures that need to be done for a given condition, but the equivalent for physician groupings doesn't exist. Therefore, after working with providers on this, I recommend the following language. The key words below are "presenting conditions" by which I mean what the patient says when they call the doctor. If I hurt my ankle, I call the doctor and say I think I sprained my ankle. That is the language we want the top 50 list to be in.

Also, I put a note at the end. Some of the providers included in the definition of "health care provider", like chiropractors and dentists, won't have 50 services/procedures they conduct on a regular basis. They probably have 20 procedures they do 90% of the time, and we only want them to be required to post those prices. They shouldn't have to post prices for procedures they only do once or twice a year. How do we word that?

Page 4, line 11-19

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 most frequent health care services, diagnostic tests, or procedures, relevant to the treatment of a particular presented condition. The information under this subdivision shall be classified in the form of diagnosis-related groups, if provided concerning inpatient services and conducted by a hospital, or in the form of presenting conditions, which shall include the total cost of current procedural terminologies (CPTs) of the American Medical Association most frequently performed as the result of the presenting condition, if provided by a physician. For other health care providers, the information under this subdivision shall be classified in a similar grouping form that corresponds to the health care providers most frequently requested services and shall be limited to services performed on a regular basis. (Note: I'm trying to get at the fact that some providers, like chiros and dentists, probably don't have 50 services to list)

From: Kennedy, Debora
Sent: Tuesday, October 16, 2007 2:50 PM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

Yes.

From: Hudzinski, Nicole
Sent: Tuesday, October 16, 2007 2:45 PM
To: Kennedy, Debora
Subject: RE: disclosure bill

Thanks Debora. I sent some hand written changes over via a page.

Regarding question 3, I think we should use the same terminology throughout. Is that OK?

From: Kennedy, Debora
Sent: Tuesday, October 16, 2007 2:38 PM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

1. We define terms that are used frequently and have a specific meaning. We do not use examples in defining, if at all possible, because it's somewhat uncertain what a court will do with the examples; that is, a court may narrow an interpretation to the examples specified or may interpret the defined term broadly. The term "health care service, diagnostic test, or procedure" would be difficult to define very specifically and yet retain the breadth that you seem to want.
2. Yes; the page 4, line 4 reference should be (5).
3. Do you want the term "health care service, diagnostic test, or procedure" to be used in s. 632.798, as well as s. 146.903?
4. Our FAX number is 264-6948.

From: Hudzinski, Nicole
Sent: Tuesday, October 16, 2007 1:26 PM
To: Kennedy, Debora
Subject: RE: disclosure bill

This is a very good draft. Below are my comments/questions:

1.) How do you decide what to define in the bill? Do you think we need to define "health care service, diagnostic test, or procedure"? To make it clear this should be reported in the form of something that makes sense to the consumer, like "knee replacement" or "cesarean delivery" or "broken arm"?
2.) On page 4, line 4, should that reference (5) instead of (4)? Small provider groups (3 or fewer) are exempt from all requirements in this bill, not just the requirement to post that the information is available. They are exempt from all of section 5(2), (3) and (4).
3.) I like the use of "health care service, diagnostic test, or procedure" and I think we should use that language in all sections. (Some sections only say "health care service" or "health service") Can you please add "diagnostic test or procedure" to all places that mention it?

That's all I have for now. I'll make specific language changes on the document and fax it over to you. What's your fax?

Thanks,
Nicole

From: Kennedy, Debora
Sent: Tuesday, October 16, 2007 10:26 AM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

According to our records, it has been submitted to you.

From: Hudzinski, Nicole
Sent: Tuesday, October 16, 2007 10:19 AM
To: Kennedy, Debora
Subject: RE: disclosure bill

Is it possible to get an estimate of when a new draft will be ready?

From: Kennedy, Debora
Sent: Friday, October 12, 2007 12:08 PM
To: Hudzinski, Nicole
Subject: RE: disclosure bill

I believe that it was redrafted Monday or Tuesday, but the editors and typists have been pretty busy since.

From: Hudzinski, Nicole
Sent: Friday, October 12, 2007 12:07 PM
To: Kennedy, Debora
Subject: disclosure bill

Hi Debra, I just wanted to check in and see how it was going with the redraft? I'm sure you're busy working on the Gov's compromise budget and I completely understand, but I just wanted to check in.

Have a good weekend,
Nicole

MONDAY AM

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-3210/P2
DAK&PJK:cjs:jf

D-NOTE

5 Fays

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

D-note (ci 10-16)

, assuming no complications,

Rege Cat

must be updated annually and

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.

presenting

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 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 for inpatient or outpatient health care services, diagnostic tests, or procedures provided by the health care provider that the consumer specifies. In addition, on request, the health care provider must immediately, on site, provide the consumer with all of the following information, as a single document:

upon

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 conditions, that the health care provider most frequently performs.

INSERT A

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~~ for the provider's 50 most frequently performed health care services, tests, or procedures.

diagnostic

diagnostic (use 2x)

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

4. The average of the charges and payment rates for each health care service, 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.

→ FE-S/L ←

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 service, before any discount or contractual rate applicable to certain patients or payers is applied.

(2) Except as provided in sub. (4), 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 conditions, that the health care provider most frequently performs. The information under this subdivision shall be classified in the form of diagnosis-related groups, if provided concerning inpatient services and by a hospital, or in the form of a code under the Current Procedural Terminology of the American Medical Association, if provided by a physician.

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, tests, or procedures specified in subd. 1.

3. The average allowable payment from private, 3rd party payers for the health care services, 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, 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) 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 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)

INSERT A

no ¶ 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.

INSERT 4-19

(no #) 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. groups.

(¶) b. If provided by a physician, in the form of presenting conditions, including the total charges for codes 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 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, procedures diagnostic tests, or procedures that the health care provider performs on a regular basis.

E.D.T.
INS
4-19

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3210/1dn
PJK:...:...
cjs
&DAK

I did not add "diagnostic, test, or procedure" after "health care service" in s. 632.798. In ch. 632, "health care service" includes "diagnostic tests" and "procedures." Throughout the chapter, there are insurance coverage requirements related to services, items (medical supplies), and drugs. Services include everything that is not an item or a drug. I'm concerned that if I add "diagnostic test, or procedure" after "health care service" in s. 632.798, all of the other places in ch. 632 that mention "health care service" might then be interpreted as not including "diagnostic tests" or "procedures."

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

~~DRAFTER'S NOTE~~

Hudzinski

To Nicole Hudzinski:

1. In drafting changes that resulted in s. 146.903 (2) (b) 1. c., as requested, I did not draft requirements proposed about requested "most frequently requested" services; this request conflicts with the overall with the overall requirement for most frequently performed ~~performed~~ services, tests, or procedures.

Please review.

~~DAK~~

2. I added "or outpatient" under s. 146.903 (2) (b) 1. a., because otherwise the classifications, as proposed, do not cover these services.

3. Because of Pam's Drafter's Note, I ~~did not~~ included only "health service" in s. 146.903 (4) (a) + (b). (care)

DAK

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3210/1dn
PJK&DAK:cjs:pg

October 22, 2007

I did not add "diagnostic test, or procedure" after "health care service" in s. 632.798. In ch. 632, "health care service" includes "diagnostic tests" and "procedures." Throughout the chapter, there are insurance coverage requirements related to services, items (medical supplies), and drugs. Services include everything that is not an item or a drug. I'm concerned that if I add "diagnostic test, or procedure" after "health care service" in s. 632.798, all of the other places in ch. 632 that mention "health care service" might then be interpreted as not including "diagnostic tests" or "procedures."

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

To Nicole Hudzinski:

1. In drafting changes that resulted in s. 146.903 (2) (b) 1. c., as requested, I did not draft requirements proposed about "most frequently" requested services; this request conflicts with the overall requirement for most frequently performed services, tests, or procedures. Please review.

2. I added "or outpatient" under s. 146.903 (2) (b) 1. a., because otherwise the classifications, as proposed, do not cover these services.

3. Because of Pam's Drafter's Note, I included only "health care service" in s. 146.903 (4) (a) and (b).

Debora A. Kennedy
Managing Attorney
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E-mail: debora.kennedy@legis.wisconsin.gov