2007 DRAFTING REQUEST

Senate Substitute Amendment (SSA-SB337)

Received: **12/17/2007**

Received By: **pkahler**

Wanted: **As time permits**

Identical to LRB:

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

By/Representing: **Nicole Hudzinski**

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:

Pre Topic:

No specific pre topic given

Topic:

Disclosure of payment information by health care providers and insurers

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	dkennedy 01/09/2008	csicilia 01/10/2008		_____ _____			
/1			pgreensl 01/10/2008	_____ _____	sbasford 01/10/2008	sbasford 01/10/2008	
/2	dkennedy 01/11/2008 pkahler 01/11/2008	csicilia 01/15/2008	rschluet 01/15/2008	_____ _____ _____ _____	mbarman 01/15/2008	mbarman 01/15/2008	

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	dkennedy 01/11/2008			_____ _____			

FE Sent For:

<END>

01-29-2008
("1/2")

See attached

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Carbon copy (CC:) to: nicole.hudzinski@legis.wi.gov

Pre Topic:

No specific pre topic given

Topic:

Disclosure of payment information by health care providers and insurers

Instructions:

See Attached

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/?	dkennedy 01/09/2008	csicilia 01/10/2008		_____ _____			
/1			pgreensl 01/10/2008	_____ _____	sbasford 01/10/2008	sbasford 01/10/2008	

FE Sent For: 1/2 cjs 1/15 08 **<END>**

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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	dkennedy	1 cjs 1/10/07	1/10 pk	1/10 pk 1/15			

FE Sent For:

<END>

12/17/07 Mtg: Pam Kahler, Nicole Hudzinski, DAK

Drafting for sub:

p. 5, ll 5-12 - DHFS to promulgate rules, after first consulting with Wis. Health Care Collaborative, to determine 25 health care services, or have examining boards for non-physician professions produce

Penalties:

50.38 as model? She (Nicole) will suggest

Revisions to SB 337

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

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

Kennedy, Debora

From: Hudzinski, Nicole
Sent: Friday, January 04, 2008 4:40 PM
To: Kennedy, Debora; Kahler, Pam
Subject: SB 337 sub amendment

calendar

Debora and Pam,

Below is my homework for the sub amendment. If you have additional questions or need more information from me, please let me know.

Definition for 'median billed charge' (replacing the term usual and customary): median amount that a health care provider has charged, before any discount or contractual rate applicable to certain patients or payers is applies, for the specified service in the most recent two quarters, allowing one quarter to accommodate the lag. The median billed charge shall be calculated by arranging the charges in the reporting period from the highest to lowest and selecting the middle charge in the sequence. The median billed charge shall be the average of the two middle charges when the sequence has an even number of charges.

Does this language make sense? I was going to use "the most recent 12 months", but WHA tells me the data can't be published immediately and we need to account for the lag time it takes them to process the data.

Regarding standardizing the top 50 list, breaking it out by specialty, and reducing it to 25, we'd like to defer to DHFS to set the list of specialties. Medicine has evolved so many new specialties over the last decade and it appears that will continue.

Requiring outpatient services provided by a hospital and reporting it by surgical procedure code, this should not conflict with the physician reporting since hospitals will only be reporting their hospital charges for these procedures. The physicians will still be required to report their charges in the form of presenting conditions. This is unfortunately a problem with our system; separate billing.

Regarding a language change for the average payment from 3rd party payers (page 5, lines 17-18), I'm still waiting to hear back from WHA. Lets leave as currently drafted for now.

Regarding penalties on the provider side, please build in an administrative forfeiture of $500.

Regarding penalties on the insurance side, please build in reference to the penalties already in the statutes as you think would be best. (I'm still confused with this part, but I don't want to reinvent the wheel here. Whatever already exists for penalties is what we'll go with).

Is there anything else I owe you?

When do you think the sub amendment will be ready?

Also, Rep. Wieckert, our Assembly lead, would like to change his draft to match or draft as revised by the sub amendment and make his a draft /2.

Have a good weekend,
Nicole

Kennedy, Debora

From: Hudzinski, Nicole
Sent: Sunday, January 06, 2008 1:58 PM
To: Kahler, Pam
Cc: Kennedy, Debora
Subject: RE: SB 337 sub amendment

Pam, please proceed with this part however you think it should be done.

When do you think the sub amendment will be ready?

Also, my fiancé had a passing in his family so I will be out of the office tomorrow and Tuesday. Please feel free however to call me on my cell if you have questions. 608-225-4042. We're hoping to get the sub done as quickly as possible. We're running out of session days.

Nicole

From: Kahler, Pam
Sent: Friday, January 04, 2008 5:02 PM
To: Hudzinski, Nicole
Cc: Kennedy, Debora
Subject: RE: SB 337 sub amendment

Nicole:

A reference to s. 601.64 should not be necessary because s. 601.64, by its own terms, applies to any violation of an insurance statute. I found that a few "insurance statutes" do actually say something to the effect that the penalties under s. 601.64 apply to a violation of the statute, but I would prefer not to add anything because then that calls into question all the other insurance statutes that do not say anything, i.e., what, if any, penalties apply? If you would like me to, I could contact OCI and make sure that they interpret s. 601.64 as applying to violations of all insurance statutes (chs. 600 to 655). Let me know if you would like me to do that.

Pam

From: Hudzinski, Nicole
Sent: Friday, January 04, 2008 4:40 PM
To: Kennedy, Debora; Kahler, Pam
Subject: SB 337 sub amendment

Debora and Pam,

Below is my homework for the sub amendment. If you have additional questions or need more information from me, please let me know.

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Also, Rep. Wieckert, our Assembly lead, would like to change his draft to match or draft as revised by the sub amendment and make his a draft /2.

Have a good weekend,
Nicole

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBs0205/?dn
PJK:/...:...

For the suggested change to s. 632.798 (2) (b), I changed "according to the *insured* benefit terms" to "according to the *insured's* benefit terms." I assumed they were referring to the insured person. If they really did intend "*insured* benefit terms," I don't know what they are referring to.

For that same provision, I did not specify "after the insured has provided all necessary information." Newly created s. 632.798 (2) (e) provides that the insurer may require the insured to provide that information before the insurer provides *any* of the information.

Adding contracts between providers and health care plans to the initial applicability makes sense only if there are contracts or agreements between providers and health care plans under which the plans (insurers) agree not to disclose information about how much they will pay providers or how much enrollees will have to pay beyond what the plans pay. I don't know if there are such agreements. However, it does not hurt to include more than necessary in this case. In a previous version of the bill, an initial applicability addressing contracts between providers and health care plans referred to a provision in ch. 609, which is no longer in the bill, that prohibited plans from prohibiting providers from disclosing their charges. So the addition to the initial applicability provision in this substitute amendment has a different focus.

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

1. Please review my wording of definitions for "all-patient refined diagnosis-related groups" and "median billed charge."

2. As requested, I added "Medicare payment rates" under s. 146.903 (2) (b) 3. What entity is to provide these? (I am not at all sure that DHFS has all of them and cannot find reference to them on the DHFS website.)

3. Your instructions for changes to s. 146.903 (2) (b) 4. conflict; the WHA language asks for the percentage of charges collected by the provider from insurers, whereas your intent seems to be to provide the average dollar amount of discounts provided by providers to insurers. The WHA language refers to a nonexistent provision of the Wisconsin Administrative Code; if, instead, the WHA is referring to the statutes, s. 153.21 (2), stats., specifies an annual consumer guide published by WHA. I do not know if the guide specifies the percentage of charges collected from insurers, and I'm not sure if that is what you want, anyway.

4. Is the effective date what you now want?

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

2005 Date (time) needed THUR LRBs 0205 / 1

DAK:RJK:gjs

SUBSTITUTE AMENDMENT [TO A BILL]

Use the appropriate components and routines developed for substitute amendments.

D-note

S A SUBSTITUTE AMENDMENT

TO 2005 SB AB 337 (337) (LRB- /)

full text SA

AN ACT . . . [generate catalog] ***to repeal*** . . . ; ***to renumber*** . . . ; ***to consolidate and renumber*** . . . ; ***to renumber and amend*** . . . ; ***to consolidate, renumber and amend*** . . . ; ***to amend*** . . . ; ***to repeal and recreate*** . . . ; and ***to create*** . . . of the statutes; **relating to:** .....

.....

.....

.....

.....

[NOTE: See section 4.02 (2) (br), Drafting Manual, for specific order of standard phrases.]

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

SECTION #.

State of Wisconsin
2007 - 2008 LEGISLATURE

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

2007 SENATE BILL 337

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

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

Analysis by the Legislative Reference Bureau

This ~~bill~~ requires health care providers, as defined ~~and limited~~ in the ~~bill~~, to provide health care consumers with certain charge or payment rate information, upon request by and at no cost to the consumers; the information must be updated annually and may not be construed as a legally binding estimate. Under the ~~bill~~, a health care provider must, within a reasonable period of time after the request, provide the consumer with the ~~usual and customary~~ charges, assuming no complications, for inpatient or outpatient health care services, diagnostic tests, or procedures provided by the health care provider that the consumer specifies. In addition, upon request, the health care provider must immediately, on site, provide the consumer with all of the following information, as a single document:

1. The ~~usual and customary~~ charge, assuming no medical complications, for each of ~~the 50~~ health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, ~~that the health care provider most frequently performs~~. This information must be classified ~~in the form of~~ diagnosis-related groups, if provided by a hospital; ~~in the form of~~ presenting conditions, if provided by a physician; and ~~in~~ a grouping form similar to that for a

SENATE BILL 337

3. If the health care provider is certified as a provider of Medicare, the Medicare payment rates.

hospital or a physician, if provided by a health care provider that is not a hospital or a physician.

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

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

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

Under the ~~bill~~, a self-insured health plan of the state or a county, city, village, town, or school district, or an insurer that provides coverage under a health insurance policy, including defined network plans and sickness care plans operated by cooperative associations, must provide to an insured under the health insurance policy or an enrollee under the self-insured health plan a good faith estimate of the reimbursement that the insurer or self-insured health plan would expect to pay a specified provider for a specified health care service. In addition, the insurer or self-insured health plan must provide to an insured or enrollee a good faith estimate of the insured's or enrollee's total out-of-pocket cost for the specified service provided by the specified provider. The information must be provided only if the insured or enrollee requests it, and it must be provided at no charge to the insured or enrollee. Any good faith estimate provided is not a legally binding estimate.

The ~~bill~~ also requires health care providers to display prominently statements informing health care consumers of the consumers' right to request charge or payment rate information for health care services, diagnostic tests, or procedures from the health care providers or from their insurers.

For further information see the ***state and local*** fiscal estimate, ~~which will~~ be printed as an appendix to this bill.

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

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

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

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

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

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

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

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

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

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

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

INSERT 3-18

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

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

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

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

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

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

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

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

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

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

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

under a classification of physician specialties that is specified by the department,

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

c. If provided by a health care provider other than a hospital or physician, ~~in~~ a grouping form similar to that under subd. 1. a. ~~or~~ b. Notwithstanding the requirement under subd. 1. (intro.) that ~~50~~ 25 health care services, diagnostic tests, or procedures be disclosed, if the health care provider under this subd. 1. ~~c.~~ d. performs fewer than ~~50~~ 25 health care services, diagnostic tests, or procedures on a regular basis, the health care provider shall indicate that fact and disclose those health care services, diagnostic tests, or procedures that the health care provider performs on a regular basis.

2. If the health care provider is certified as a provider of Medical Assistance, the Medical Assistance payment rates, 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.

INSERT 5-16

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

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

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

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

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

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

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

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

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

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

INSERT 6-15

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 median 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)

generally under the policy or plan. The requirement does not apply to limited benefit plans, such as vision or dental plans, or to Medicare supplement policies.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

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

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to ~~(5)~~ (6), 632.895 (5m) and (8) to ~~(15)~~ (16), and 632.896.

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

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to ~~(15)~~ (16).

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

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to ~~(15)~~ (16), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

SECTION 4. 111.91 (2) (n) of the statutes is amended to read:

insert 3-15 cont'd 2d

111.91 **(2)** (n) The provision to employees of the health insurance coverage required under s. 632.895 (11) to (14), and (16).

SECTION 5. 120.13 (2) (g) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to ~~(15)~~ (16), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

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

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (10) to ~~(15)~~ (16), and 632.897 (10) and chs. 149 and 155.

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

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (5) and (9) to ~~(15)~~ (16), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 8. 609.835 of the statutes is created to read:

(end of ins 3-15)

Insert 7-3

111.91 **(2)** (n) The provision to employees of the health insurance coverage required under s. 632.895 (11) to (14), and (16).

SECTION 5. 120.13 (2) (g) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to ~~(15)~~ (16), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

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

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (10) to ~~(15)~~ (16), and 632.897 (10) and chs. 149 and 155.

632.798,

plain

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

632.798,

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, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (5) and (9) to ~~(15)~~ (16), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

plain

SECTION 8. 609.835 of the statutes is created to read:

(and 9 of insert 7-3)

INSERT A

Under the substitute amendment, a violation of these requirements is subject to an administrative forfeiture of up to $500.

INSERT 3-18

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

INSERT 4-8 A

not , during the 2 calendar quarters immediately preceding the most recently completed calendar quarter, as calculated by arranging the charges in that reporting period from highest to lowest and selecting the middle charge in the sequence or, for an even number of charges, selecting the 2 middle charges in the sequence and calculating the average of the 2

INSERT 4-8 B

(h) "Medicare" means coverage under part A or part B of title XVIII of the federal social security act, 42 USC 1395 to 1395dd.

INSERT 4-24

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

INSERT 5-16

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

INSERT 6-15

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

alleged violator

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

(c) An alleged violator may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (b), a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1). The administrator of the division may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator of the division shall be the final administrative decision. The division shall commence the hearing within 30 days after receipt of the request for a hearing and shall issue a final decision within 15 days after the close of the hearing. Proceedings before the division are governed by ch. 227. In any petition for judicial review of a decision by the division, the party, other than the petitioner, who was in the proceeding before the division shall be the named respondent.

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

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

INSERT 2-B

Before providing any of the information, the insurer or self-insured health plan may require the insured or enrollee to provide the name of the provider providing the service, the facility at which the service will be provided, the date the service will be provided, and the provider's estimate of the charges. However, the insurer or self-insured health plan may not require the insured or enrollee to provide the Current Procedural Terminology code or Current Dental Terminology code for the service as a condition of providing the information. In addition, the bill provides that

(END OF INSERT 2-B)

INSERT 7-18

in the geographic region in which the health care service will be provided

(END OF INSERT 7-18)

INSERT 7-19

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

(END OF INSERT 7-19)

INSERT 8-2

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

a. The name of the provider providing the service.

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

c. The date the service will be provided.

Ins. 8-2 cont'd

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

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

(END OF INSERT 8-2)

INSERT 8-6

, or a contract or agreement between a provider and a health care plan that is in effect on the effective date of this subsection,

(END OF INSERT 8-6)

INSERT 8-11

, or contract or agreement

(END OF INSERT 8-11)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBs0205/1dn
PJK:cjs:pg

January 10, 2008

For the suggested change to s. 632.798 (2) (b), I changed "according to the *insured* benefit terms" to "according to the *insured's* benefit terms." I assumed they were referring to the insured person. If they really did intend "*insured* benefit terms," I don't know what they are referring to.

For that same provision, I did not specify "after the insured has provided all necessary information." Newly created s. 632.798 (2) (e) provides that the insurer may require the insured to provide that information before the insurer provides *any* of the information.

Adding contracts between providers and health care plans to the initial applicability makes sense only if there are contracts or agreements between providers and health care plans under which the plans (insurers) agree not to disclose information about how much they will pay providers or how much enrollees will have to pay beyond what the plans pay. I don't know if there are such agreements. However, it does not hurt to include more than necessary in this case. In a previous version of the bill, an initial applicability addressing contracts between providers and health care plans referred to a provision in ch. 609, which is no longer in the bill, that prohibited plans from prohibiting providers from disclosing their charges. So the addition to the initial applicability provision in this substitute amendment has a different focus.

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

1. Please review my wording of definitions for "all-patient refined diagnosis-related groups" and "median billed charge."

2. As requested, I added "Medicare payment rates" under s. 146.903 (2) (b) 3. What entity is to provide these? (I am not at all sure that DHFS has all of them and cannot find reference to them on the DHFS website.)

3. Your instructions for changes to s. 146.903 (2) (b) 4. conflict; the WHA language asks for the percentage of charges collected by the provider from insurers, whereas your

intent seems to be to provide the average dollar amount of discounts provided by providers to insurers. The WHA language refers to a nonexistent provision of the Wisconsin Administrative Code; if, instead, the WHA is referring to the statutes, s. 153.21 (2), stats., specifies an annual consumer guide published by WHA. I do not know if the guide specifies the percentage of charges collected from insurers, and I'm not sure if that is what you want, anyway.

4. Is the effective date what you now want?

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

Kahler, Pam

From: Hudzinski, Nicole
Sent: Friday, January 11, 2008 1:38 PM
To: Kahler, Pam
Subject: RE: LRB 07s0205 Topic: Disclosure of payment information by health care providers and insurers

I'll send the jacket back.

Yes, please add an initial applicability that applies the any contracts with inconsistent provisions on the days it is modified, extended, or renewed. This needs to include contracts between a health plan and an enrollee and the contracts between the health plan and the provider groups.

From: Kahler, Pam
Sent: Friday, January 11, 2008 1:27 PM
To: Hudzinski, Nicole
Subject: RE: LRB 07s0205 Topic: Disclosure of payment information by health care providers and insurers

Nicole:

You will need to send us the jacket back for us to redraft this. As to your comment regarding my third point, unless you really want us to add some prohibitions, they should not be necessary for future contracts. When we require or prohibit someone from doing something in the statutes, we do not also prohibit contracts that allow the opposite - that is a given. The problem is with contracts that are in existence when the statute goes into effect. To address those cases, we draft an initial applicability that says the provisions apply to any contracts with inconsistent provisions on the day it is modified, extended, or renewed - as the sub does for the insurance provisions. I can add the provider provisions that Debora drafted to that initial applicability - it may be that the whole sub (this act) needs to be added, and not the separate provisions, but I will review the sub for that possibility.

From: Hudzinski, Nicole
Sent: Friday, January 11, 2008 9:53 AM
To: Kahler, Pam
Subject: FW: LRB 07s0205 Topic: Disclosure of payment information by health care providers and insurers

Regarding your first two points, both are fine with me.

Regarding your third point (contracts between providers and health plans) we need the bill to prohibit both providers and health plans from keeping this a secret. The original language (prohibiting plans from prohibiting providers from disclosing their charges) was I believe pulled from the MN language. It is my understanding however, that contracts between provider groups and health plans do contain a non-disclose agreement, and we want to prevent that in the future. We don't want providers to say health plans can't provide it and we don't want health plans to say providers can't provide it. Does that make sense?

Nicole

From: Hudzinski, Nicole
Sent: Friday, January 11, 2008 9:49 AM
To: Hudzinski, Nicole
Subject: FW: LRB 07s0205 Topic: Disclosure of payment information by health care providers and insurers

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From: Basford, Sarah
Sent: Thursday, January 10, 2008 1:55 PM
To: Sen.Sullivan

Subject: LRB 07s0205 Topic: Disclosure of payment information by health care providers and insurers

The attached proposal has been jacketed for introduction.

A copy has also been sent to:

<< File: LRB s0205_1 >> << File: LRB s0205/1 >>

Kennedy, Debora

From: Hudzinski, Nicole
Sent: Friday, January 11, 2008 2:28 PM
To: Kennedy, Debora
Subject: RE: Disclosure questions

Both your changes sound good.

Regarding sources for Medicare and Medicaid, I'd like to be general (not specify where to get it) and leave that to the rules process to be worked out. Is that OK?

I had a page bring the jacket back over about an hour ago. I sent it to Pam since she responded first.

Nicole

From: Kennedy, Debora
Sent: Friday, January 11, 2008 1:47 PM
To: Hudzinski, Nicole
Subject: RE: Disclosure questions

Nicole--

Most of your proposed changes look okay to me, except the language you propose for the definition of 'median billed charge':
"first 2 calendar quarters of the proceeding year" is not quite sufficiently explicit. I think it should be as follows:
"Median billed charge" means the amount that a health care provider charged for a health care service, diagnostic test, or procedure, before any discount or contractual rate applicable to certain patients or payers was applied, during the first 2 calendar quarters of the most recently completed calendar year, as calculated …."

A second change that should be made is with respect to the reference to the Wisconsin Collaborative for Healthcare Quality. The reference to defining the term "presenting conditions" should be made after the first mention of that term, and it should be as follows: ", as defined by DHFS after consulting with the WCHQ." We do not use "in consultation with" in this context because DHFS is the ultimate administrative agency with authority to do the defining.

As I indicated in my Drafter's Note, it is unclear from what source the Medicare payment rates will be provided.

You will need to return the jacket of the substitute amendment back to our office for a redraft.

Debora Kennedy

From: Hudzinski, Nicole
Sent: Friday, January 11, 2008 1:10 PM
To: Kennedy, Debora
Subject: Disclosure questions

The definition for APR DRG looks good to me.

After further conversations with WHA, please change the definition of 'median billed charge' to 'means the amount that a health care provider charged for a health care service, diagnostic test, or procedure, before any discount or contractual rate applicable to certain patients or payers is applies, during the **first 2 calendar quarters of the proceeding year**, as calculated by arranging…"

What I'm thinking here is that on January 1 of each year all the provider groups will need to publish prices for the list of procedures DHFS sets. The prices they publish should be based on median billed charges from the first two quarters of the previous year. So, for example, shortly after July 1, 2007 (end of the fiscal year, right), DHFS sets the lists based on MA data from July 1, 2006-July 1, 2007. On January 1, 2008, providers post prices for the procedures include in the DHFS list using data from January-June 2007. Does that make sense?

I also think it should be 'charged' instead of 'charge' since we're referring to the past tense.

Please remove the reference to the DHFS website for MA rates. I'm told critical access hospitals (which there are a lot of) don't get reimbursed based on MA payment rates. It's instead a percentage of billed charges for them. I'd like to, therefore, be more generic in this section and leave it to the rules process to define this more. Is that OK?

Regarding changes to 146.903(2)(b), please leave it as currently drafted. We do want an average dollar amount and not a percentage. WHA doesn't like that, but it's what we want.

The effective date as written in the sub is fine.

Please add (page 6, line 5) "as defined by DHFS in consultation with the Wisconsin Collaborative for Healthcare Quality" after "conditions". Since there currently isn't an agreed upon definition for what CPT codes should occur for a presenting condition, we want to require DHFS, in consultation with the Collaborative, to define it. So, for example, DHFS would define that the price estimate you give for bronchitis should be calculated by adding CPT code X plus CPT code Y plus CPT code Z. That will ensure all providers are calculating their prices the same and people can compare apples to apples. Does that make sense?

Thanks Debora. I leave for vacation Monday at noon. If possible, please call me before then if you have questions. Otherwise, I'll try to check my email from vacation. Thanks for all your help on this.

Nicole

From: Hudzinski, Nicole
Sent: Friday, January 11, 2008 9:49 AM
To: Hudzinski, Nicole
Subject: FW: LRB 07s0205 Topic: Disclosure of payment information by health care providers and insurers

---

From: Basford, Sarah
Sent: Thursday, January 10, 2008 1:55 PM
To: Sen.Sullivan
Subject: LRB 07s0205 Topic: Disclosure of payment information by health care providers and insurers

The attached proposal has been jacketed for introduction.

A copy has also been sent to:

<< File: LRB s0205_1 >> << File: LRB s0205/1 >>

WED., 1/16/08

State of Wisconsin
2007 - 2008 LEGISLATURE

LRBs0205/1~~2~~
DAK&PJK:cjs:~~pg~~

SENATE SUBSTITUTE AMENDMENT ,

TO 2007 SENATE BILL 337

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

Analysis by the Legislative Reference Bureau

This substitute amendment requires health care providers, as defined in the substitute amendment, to provide health care consumers with certain charge or payment rate information, upon request by and at no cost to the consumers; the information must be updated annually and may not be construed as a legally binding estimate. Under the substitute amendment, a health care provider must, within a reasonable period of time after a consumer's request, provide the consumer with the median billed charges (as defined in the substitute amendment), assuming no complications, for inpatient or outpatient health care services, diagnostic tests, or procedures provided by the health care provider that the consumer specifies. In addition, upon request, the health care provider must immediately, on site, provide the consumer with all of the following information, as a single document:

1. The median billed charge, assuming no medical complications, for each of 25 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, as specified annually by the Department of Health and Family Services (DHFS). This information must be classified by

diagnosis-related groups or all-patient refined diagnosis-related groups, if provided by a hospital for inpatient services; by surgical procedure code, if provided by a hospital for outpatient services or if provided by an ambulatory surgery center; by presenting conditions, if provided by a physician; and by a grouping form similar to that for a hospital or a physician, if provided by a health care provider that is not a hospital or a physician.

2. If the health care provider is certified as a provider of Medical Assistance (MA), the MA payment rates, ~~as specified on the Web site of the Department of Health and Family Services,~~ for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

3. If the health care provider is certified as a provider of Medicare, the Medicare payment rates for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

4. The average allowable payment from private, third-party payers for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

Under the substitute amendment, a violation of these requirements is subject to an administrative forfeiture of up to $500.

Under the substitute amendment, a self-insured health plan of the state or a county, city, village, town, or school district, or an insurer that provides coverage under a health insurance policy, including defined network plans and sickness care plans operated by cooperative associations, must provide to an insured under the health insurance policy or an enrollee under the self-insured health plan a good faith estimate of the median reimbursement that the insurer or self-insured health plan would expect to pay for a specified health care service in the geographic region in which the service will be provided. In addition, the insurer or self-insured health plan must provide to an insured or enrollee a good faith estimate of the insured's or enrollee's total out-of-pocket cost for the specified service. The information must be provided only if the insured or enrollee requests it, and it must be provided at no charge to the insured or enrollee. Before providing any of the information, the insurer or self-insured health plan may require the insured or enrollee to provide the name of the provider providing the service, the facility at which the service will be provided, the date the service will be provided, and the provider's estimate of the charges. However, the insurer or self-insured health plan may not require the insured or enrollee to provide the Current Procedural Terminology code or Current Dental Terminology code for the service as a condition of providing the information. In addition, the substitute amendment provides that any good faith estimate provided is not a legally binding estimate.

The substitute amendment also requires health care providers to display prominently statements informing health care consumers of the consumers' right to

request charge or payment rate information for health care services, diagnostic tests, or procedures from the health care providers or from their insurers.

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) "Clinic" means a place, other than a residence, that is used primarily for the provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and treatment.

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

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

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

charges, selecting the 2 middle charges in the sequence and calculating the average of the 2.

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

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

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

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

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

1. The median billed charge, assuming no medical complications, for each of 25 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, as specified annually by the department based on claims data under Medical Assistance from the most recently-completed fiscal year. The information under this subdivision shall be classified as follows:

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

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

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

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

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

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

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

(4) Except as provided in sub. (5), a health care provider shall prominently display, in the area of the health care provider's practice or facility that is most commonly frequented by health care consumers, a statement informing the consumers that they have the right to request charge or payment rate information for health care services, diagnostic tests, or procedures from the health care provider or, if the requirements under s. 632.798 (2) (e) are met, all of the following from their insurers or self-insured health plans:

(a) A good faith estimate of the median reimbursement that the insurer or self-insured health plan would expect to pay for a specified health care service in the geographic region in which the health care service will be provided.

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

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

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

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

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

(b) The department may directly assess forfeitures provided for under par. (a). If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the alleged violator. The notice shall specify the amount of the forfeiture assessed, the violation, and the

statute or rule alleged to have been violated, and shall inform the alleged violator of the right to a hearing under par. (c).

(c) An alleged violator may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (b), a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1). The administrator of the division may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator of the division shall be the final administrative decision. The division shall commence the hearing within 30 days after receipt of the request for a hearing and shall issue a final decision within 15 days after the close of the hearing. Proceedings before the division are governed by ch. 227. In any petition for judicial review of a decision by the division, the party, other than the petitioner, who was in the proceeding before the division shall be the named respondent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The name of the provider providing the service.

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

c. The date the service will be provided.

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

2. The insurer or self-insured health plan may not require an insured to provide the code for the service under the Current Procedural Terminology of the American Medical Association or under the Current Dental Terminology of the

American Dental Association as a condition for providing the information requested under par. (a) or (b).

SECTION 10. Initial applicability.

(1) DISCLOSURE OF PAYMENTS AND OUT-OF-POCKET COSTS. If a disability insurance policy or a governmental self-insured health plan that is in effect on the effective date of this subsection, or a contract or agreement between a provider and a health care plan that is in effect on the effective date of this subsection, contains a provision that is inconsistent with 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, governmental self-insured health plan, or contract or agreement on the date on which it is modified, extended, or renewed.

SECTION 11. Effective date.

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

(END)

Barman, Mike

From: Hudzinski, Nicole
Sent: Tuesday, January 29, 2008 12:19 PM
To: Barman, Mike
Subject: RE: fiscal note for sub amendment

So I need to send this to Risser's office and ask them to send it to you and DOA?

Per Joint Rule 41 (3) (b), Senator Sullivan requests a fiscal estimate by DHFS on his Senate Substitute Amendment to 2007 SB 337. Prior to being introduced the bill was LRB 3424/2 and the sub amendment was LRB 0205/2.

From: Barman, Mike
Sent: Tuesday, January 29, 2008 12:07 PM
To: Hudzinski, Nicole
Subject: RE: fiscal note for sub amendment

<< File: FE's - Supplemental FE E-Mail.doc >>

From: Hudzinski, Nicole
Sent: Tuesday, January 29, 2008 12:04 PM
To: Barman, Mike
Subject: FW: fiscal note for sub amendment

Mike, can you please tell me what I need to do to request a fiscal note on our sub amendment to SB 337?

Nicole
Sen. Sullivan's office

From: Kennedy, Debora
Sent: Tuesday, January 29, 2008 11:49 AM
To: Hudzinski, Nicole
Subject: RE: fiscal note for sub amendment

According to Joing Rule 41 (3) (b), Senator Sullivan may request the Senate President to request (through DOA) that DHFS prepare a supplemental fiscal estimate of the bill as affected by the substitute amendment--as you can see, we do not automatically request fiscal estimates for substitute amendments. If you contact Mike Barman, Senior Program Assistant at the LRB (at 6-3561), he will send you an e-mail that details the procedures.

From: Hudzinski, Nicole
Sent: Tuesday, January 29, 2008 11:30 AM
To: Kennedy, Debora
Subject: fiscal note for sub amendment

Debora, do I have to formally request a fiscal note on the sub amendment? If so, can I request that now?

Nicole

Barman, Mike

From: Cieslewicz, Dianne
Sent: Tuesday, January 29, 2008 1:41 PM
To: *DOA Fiscal Estimates; LRB.Legal
Subject: FW: fiscal note request on sub amendment

This message/request is from Senator Fred Risser. If there are any questions please call Dianne at 266-1627.

From: Hudzinski, Nicole
Sent: Tuesday, January 29, 2008 12:59 PM
To: Cieslewicz, Dianne
Subject: fiscal note request on sub amendment

Diane, it's my understanding I need to send you this email if I want a fiscal note on our sub amendment. Can you please forward to the DOA fiscal estimate coordinator at DOA (fes@doa.state.wi.us) and Vicky LaBelle at LRB (lrb.legal@legis.wisconsin.gov)

Per Joint Rule 41 (3) (b), Senator Sullivan requests a fiscal estimate by DHFS on his Senate Substitute Amendment to 2007 SB 337. Prior to being introduced the bill was LRB 3424/2 and the sub amendment was LRB 0205/2.