WISCONSIN LEGISLATIVE COUNCIL
AMENDMENT MEMO

2007 Assembly Bill 729	Assembly Substitute Amendment 1 and Assembly Amendment 1 to Assembly Substitute Amendment 1
Memo published: **March 5, 2008**	*Contact*: **Scott Grosz, Staff Attorney (266-1307)**

ASSEMBLY SUBSTITUTE AMENDMENT 1 TO 2007 ASSEMBLY BILL 729

Health Care Provider Information Specific to a Patient

Assembly Substitute Amendment 1 requires a health care provider[1], including a clinic and an ambulatory surgery center, or the provider's designee, to provide upon request, and at no cost to a health care patient; the median billed charges[2], assuming no medical complications, and the appropriate code under the Current Procedural Terminology of the American Medical Association, for an inpatient or outpatient health care service, diagnostic test, or procedure that is specified by the patient and that is provided by the health care provider. This information must be provided within a reasonable period of time.

[1] "Health care provider" is defined as any of the following, or a partnership, corporation, or limited liability company of any of these providers: a chiropractor, dentist, physician, physician assistant, perfusionist, respiratory care practitioner, physical therapist, podiatrist, dietitian, athletic trainer, occupational therapist, occupational therapy assistant, optometrist, pharmacist, acupuncturist, psychologist, social worker, marriage and family therapist, professional counselor, speech and language pathologist, audiologist, massage therapist, or bodyworker.

[2] "Median billed charges" is defined as 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 two calendar quarters of the most recently completed calendar year, as calculated by arranging the charges in that reporting period from highest to lowest and selecting the middle charge in the sequence or, for an even number of charges, selecting the two middle charges in the sequence and calculating the average of the two.

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Provider Information on Frequently Performed Services, Tests, and Procedures

The substitute amendment requires a health care provider to provide to a health care patient all of the following information, which must be provided immediately upon request on the site of the health care provider:

- The median billed charge (assuming no medical complications) for each of the 25 most frequently performed health care services, diagnostic tests, or procedures relevant to the treatment of presenting conditions that the health care provider performs. The information must be classified:

  - For inpatient services by a hospital: in diagnosis-related group (DRG) or all-patient refined DRG form.

  - For outpatient services provided by a hospital or ambulatory surgical center: by surgical procedure code.

  - For information provided by a physician: in the form of presenting conditions, including charges for the Current Procedural Terminology (CPT) codes that are most frequently performed for the presenting conditions. The information must be provided under a classification of specialties as specified by the Department of Health and Family Services (DHFS). The DHFS must define "presenting conditions," after consulting with the Wisconsin Collaborative on Health Care Quality.

  - For information is provided by a health care provider other than a hospital or physician: in any of the three formats specified above.

Annual Update of Information

The substitute amendment requires the health care provider to annually update the information on charges provided to a patient. Also, this information may not be construed as a legally binding estimate of the cost to the patient.

Right to Request Charge Information

The substitute amendment requires a health care provider to prominently display, in the area of the provider's practice or facility most commonly frequented by health care patients, a statement informing patients that they have the right to request charge information for health care services, diagnostic tests, or procedures from the health care provider or the following from their insurers or self-insured health plans:

- 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.

The requirements outlined above do not apply to a health care provider that practices individually and not in association with another health care provider, nor do they apply to health care providers that are an association of three or fewer individual health care providers.

Forfeitures

The substitute amendment adds a $500 forfeiture for health care provider noncompliance with the above provisions, and allows DHFS to directly assess the forfeitures and provides a procedure for contesting the imposition of a forfeiture.

Insurer Estimate

The substitute amendment requires an insurer, or a self-insured health plan of the state or a county, city, village, town, or school district, to provide, at the request of an insured and without charge, a good faith estimate of the 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. An estimate provided by the insurer or self-insured health plan under this section is not a legally binding estimate.

Insurer Requirements of an Insured

The substitute amendment permits an insurer to require an insured to provide the following information before responding to an insured's request for the information required under the bill:

- The name of the provider providing the service.
- The facility at which the service will be provided.
- The date the service will be provided.
- The provider's estimate of the charge for the service.
- 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.

Delayed Effective Date

The substitute amendment has a delayed effective date of nine months, except for treatment of the forfeiture provision, which has a delayed effective date of 19 months.

ASSEMBLY AMENDMENT 1 TO ASSEMBLY SUBSTITUTE AMENDMENT 1

Health Care Provider Information Specific to a Patient

Assembly Amendment 1 amends the substitute amendment to state that a health care provider must provide the relevant code under the Current Procedural Terminology of the American Medical Association, under the Current Dental Terminology of the American Dental Association, or under the American Society of Anesthesiologists Relative Value Guide for the health care service, diagnostic test or procedure that the health care provider expects to perform. The amendment deletes the number "4" from the reference to levels of severity of illness in the definition of "all-patient refined diagnosis-related groups."

Provider Information on Frequently Performed Services, Tests, and Procedures

Assembly Amendment 1 amends Assembly Substitute Amendment 1 to specify that a health care provider must provide the median billed charge (assuming no complications) for each of the 25 presenting conditions, as specified annually by the department based on claims data under Medical Assistance for the most recently completed fiscal year. Additionally, Assembly Amendment 1 amends the substitute amendment to state that, for a hospital, the 25 presenting conditions shall be specified by the department based on health care information most recently disseminated under s. 153.05 (1) (b), Stats.

Assembly Amendment 1 also modifies the classification of information on frequently performed services, tests, and procedures. For information provided by a physician, Assembly Amendment 1 amends the substitute amendment to require codes under the Current Procedural Terminology of the American Medical Association or under the American Society of Anesthesiologists Relative Value Guide, as appropriate.

Annual Update of Information

Assembly Amendment 1 amends the substitute amendment to require health care providers to update information on charges *at least* on an annual basis.

Insurer Requirements of an Insured

Assembly Amendment 1 specifies that an insurer may require an insured to provide the codes for a service under the Current Procedural Terminology of the American Medical Association, Current Dental Terminology of the American Dental Association, or American Society of Anesthesiologists Relative Value Guide prior to responding to an insured's request for information under the substitute amendment.

Legislative History

Representatives Wieckert and Moulton offered Assembly Amendment 1 to Assembly Substitute Amendment 1 on February 20, 2008. Representative Wieckert offered Assembly Substitute Amendment 1 on February 11, 2008.

On February 20, 2008, the Assembly Committee on Small Business adopted Assembly Amendment 1 to Assembly Substitute Amendment 1 and Assembly Substitute Amendment 1 by a vote of Ayes, 9; Noes, 0. The committee recommended passage of 2007 Assembly Bill 729, as amended, by a vote of Ayes, 9; Noes, 0; on February 20, 2008.

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