State of Wisconsin
2009 − 2010 LEGISLATURE

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ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO 2009 ASSEMBLY BILL 614

February 2, 2010 − Offered by Representative RICHARDS.

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 153.21 (title), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 146.903, 153.21 (3), 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers, hospitals, and insurers and providing a penalty.

Analysis by the Legislative Reference Bureau

This substitute amendment requires a health care provider to disclose to a consumer the provider's median billed charge for a health care service, diagnostic test, or procedure, upon request. For purposes of the substitute amendment, a health care provider includes a physician, nurse, dentist, chiropractor, physical therapist, optometrist, pharmacist, psychologist, and clinic, among others, but does not include a hospital. However, the substitute amendment exempts health care providers that practice individually or in a group of less than three providers from the requirement to provide charge information for a particular service, test, or procedure.

The substitute amendment also requires both health care providers and hospitals to create a document that lists the following charge information for a specified set of conditions or procedures: 1) the provider's median billed charge; 2) the reimbursement amount under Medicare, except in the case of a provider who does not participate in Medicare; and 3) the average allowable payment from private, third−party payers. For health care providers, DHS must identify, by type of health

care provider, the 25 presenting conditions for which each type of provider most frequently provides health care services, and these are the conditions for which a health care provider must list charge information in the required document. Hospitals are required to list the charge information for the 75 conditions for which hospitals in this state most frequently provide inpatient care, as well as for the 75 outpatient surgical procedures that hospitals in this state most frequently perform. Health care providers and hospitals must, upon request, provide consumers a copy of their document listing charge information for the specified set of conditions or procedures. The substitute amendment exempts health care providers that practice individually or in a group of less than three providers from the requirement to create a document listing charges.

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 insured's or enrollee's total out−of−pocket cost for a specified health care service in the geographic region in which the service will be provided. The estimate 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 the estimate, the insurer or self−insured health plan may require the insured or enrollee to provide, in writing, 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 charges, and the Current Procedural Terminology code or Current Dental Terminology code for the service. The substitute amendment specifies that the estimate is not legally binding and is to be provided as of the date of the request and assuming no medical complications or changes to the insured's or enrollee's treatment plan. In addition, an insurer or self−insured plan is not required to provide an estimate if the provider providing the health care service practices alone or in association with only one or two other health care providers or is an association of three or fewer health care providers.

Under the substitute amendment a health care provider or hospital must prominently display notice regarding the availability of charge information that providers or hospitals are required to disclose and of the requirement that a insurer or self−insured health plan provide an an estimate of an insured's or enrollees out−of−pocket cost.

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 2009 Wisconsin Act 28, 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), 632.885, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2009 Wisconsin Act 28, 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, 632.885, and 632.895 (11) to (17).

SECTION 3. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28, 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), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28, 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), 632.885, 632.895 (9) to (17), 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 and hospitals. **(1)** DEFINITIONS. In this section:

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

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

(c) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (L) and includes a clinic and an ambulatory surgical center but does not include a nursing home, as defined in s. 50.01 (3).

(d) "Hospital" has the meaning given in s. 50.33 (2).

(e) "Median billed charge" means one of the following:

1. For a health care provider, the amount the health care provider charged, 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 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.

2. For a hospital, the amount the hospital charged, before any discount or contractual rate applicable to certain patients or payers was applied, during the 4 calendar quarters for which the hospital most recently reported data under ch. 153, as calculated by arranging the charges in the 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.

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

(2) DEPARTMENT DUTIES. (a) The department shall do all of the following:

1. Categorize health care providers by type.

2. For each type of health care provider, annually identify the 25 presenting conditions for which that type of health care provider most frequently provides health care services.

3. Prescribe the methods by which health care providers shall calculate and present median billed charges and Medicare and private 3rd−party payer payments under sub. (3) (b).

(b) In performing the duties under par. (a), the department shall consult with organizations in this state that do all of the following:

1. Develop performance measures for assessing the quality of health care services.

2. Guide the collection, validation, and analysis of data related to measures described under subd. 1.

3. Report results of assessments of the quality of health care services.

4. Share best practices of organizations that provide health care services.

(3) HEALTH CARE PROVIDER DISCLOSURE OF CHARGES. (a) Except as provided in par. (g), 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 within a reasonable period of time after the request, the median billed charge, assuming no medical complications, for a health care service, diagnostic test, or procedure that is specified by the consumer and that is provided by the health care provider.

(b) Except as provided in par. (g), a health care provider shall prepare a single document that lists the following charge information, assuming no medical complications, for diagnosing and treating each of the 25 presenting conditions identified for the health care provider's provider type under sub. (2):

1. The median billed charge.

2. If the health care provider is certified as a provider of Medicare, the Medicare payment to the provider.

3. The average allowable payment from private, 3rd−party payers.

(c) Except as provided in par. (g), a health care provider or the health care provider's designee shall, upon request by and at no cost to a health care consumer, provide the consumer a copy of the document prepared under par. (b).

(d) Except as provided in par. (g), a health care provider shall annually update the document under par. (b).

(e) Information provided upon request under par. (a) or included on the document under par. (b) does not constitute a legally binding estimate of the charge for a specific patient or the amount that a 3rd−party payer will pay on behalf of the patient.

(f) Except as provided in par. (g), 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 receive charge information as provided in pars. (a) and (b) from the health care provider and, if the requirements, if any, under s. 632.798 (2) (d) are met, a good faith estimate, from their insurers or self−insured health plans, 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.

(g) The requirements under pars. (a) to (f) do not apply to any of the following:

1. A health care provider that practices individually or in association with not more than 2 other individual health care providers.

2. A health care provider that is an association of 3 or fewer individual health care providers.

(4) HOSPITAL DISCLOSURE OF CHARGES. (a) Each hospital shall prepare a single document that lists the following charge information, assuming no medical complications, for inpatient care for each of the 75 diagnosis related groups identified under s. 153.21 (3) and the following charge information for each of the 75 outpatient surgical procedures identified under s. 153.21 (3):

1. The median billed charge.

2. The average allowable payment under Medicare.

3. The average allowable payment from private, 3rd−party payers.

(b) A hospital shall, upon request by and at no cost to a health care consumer, provide the consumer a copy of the document prepared under par. (a).

(c) A hospital shall update the document under par. (a) every calendar quarter.

(d) Information included on the document under par. (a) does not constitute a legally binding estimate of the charge for a specific patient or the amount that a 3rd−party payer will pay on behalf of the patient.

(e) Each hospital shall prominently display, in the area of the hospital that is most commonly frequented by health care consumers, a statement informing the consumers that they have the right to receive a copy of the document under par. (a) from the hospital and, if the requirements, if any, under s. 632.798 (2) (d) are met,

a good faith estimate, from their insurers or self−insured health plans, 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) PENALTY. (a) Whoever violates sub. (3) or (4) may be required to forfeit not more than $250 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. 153.21 (title) of the statutes is amended to read:

153.21 (title) **Consumer guide; list for hospital charge disclosures.**

SECTION 7. 153.21 (3) of the statutes is created to read:

153.21 **(3)** The entity under contract under s. 153.05 (2m) (a) shall, using data collected under s. 153.05 (1) (b), annually identify the 75 diagnosis related groups for which hospitals in this state most frequently provide inpatient care and the 75 outpatient surgical procedures most frequently performed by hospitals in this state, and shall distribute a list of the identified diagnosis related groups and surgical procedures to all hospitals in the state and to the department.

SECTION 8. 185.981 (4t) of the statutes, as affected by 2009 Wisconsin Act 28, 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), 632.885, 632.895 (10) to (17), and 632.897 (10) and chs. 149 and 155.

SECTION 9. 185.983 (1) (intro.) of the statutes, as affected by 2009 Wisconsin Act 28, 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), 632.885, 632.895 (5) and (9) to (17), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

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 Out−of−pocket costs. (1) DEFINITIONS. In this section:

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

(b) "Health care provider" has the meaning given in s. 146.903 (1) (c) and includes a hospital, as defined in s. 50.33 (2).

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

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

(2) PROVIDE ESTIMATE. (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, as of the date of the request and assuming no medical complications or modifications in the insured's treatment plan,

of the insured's total out−of−pocket cost according to the insured's benefit terms for a specified health care service in the geographic region in which the health care service will be provided.

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

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

(d) Before providing the information requested under par. (a), the insurer or self−insured health plan may require the insured to provide in writing any of the following information:

1. The name of the health care provider providing the service.

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

3. The date the service will be provided.

4. The health care provider's estimate of the charge for the service.

5. The codes for the service under the Current Procedural Terminology of the American Medical Association or under the Current Dental Terminology of the American Dental Association.

(e) The requirement to provide the information requested under par. (a) does not apply if the health care provider providing the health care service is any of the following:

1. A health care provider that practices individually or in association with not more than 2 other individual health care providers.

2. A health care provider that is an association of 3 or fewer individual health care providers.

SECTION 12. Initial applicability.

(1) DISCLOSURES. 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 this act, this act 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 13. Effective date.

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

(END)