WISCONSIN LEGISLATIVE COUNCIL
ACT MEMO

2009 Wisconsin Act 146 [2009 Assembly Bill 614]	Information Regarding Health Care Charges and Quality

Health Care Provider Disclosure of Charges

Act 146 requires certain information to be provided by "health care providers," as defined in the Act. That term excludes hospitals, which are covered by a provision described in the next item in this memorandum. Health care providers or their designees are required to disclose to consumers within a reasonable period of time after a request by a consumer, the median billed charge, assuming no medical complications, for a health care service, diagnostic test, or procedure that is specified by the consumer and is provided by the health care provider. The median billed charge must be provided at no cost to the consumer.

A health care provider is also required to prepare a single document that lists the following charge information, assuming no medical complications, for diagnosing and treating each of the 25 conditions identified by the Department of Health Services (DHS) for the health care provider's provider type: (1) the median billed charge; (2) the Medicare payment to the provider (if the provider is certified under Medicare); and (3) the average allowable payment from private, third-party payers. This document must be provided upon request and at no cost to a health care consumer. In addition, the health care provider must update this document annually.

Neither of these items constitutes a legally binding estimate of the charge for a specific patient or the amount that a third-party payer will pay.

A health care provider is required to display prominently a statement informing consumers that they have the right to receive charge information, as described above and, if specified requirements are met, a good faith estimate from their insurers or governmental self-insured health plans of the person's total out-of-pocket costs according to the person's benefit terms for a specified service in the geographic region in which the service will be provided.

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The above requirements do not apply to a health care provider that practices individually or in association with not more than two other individual health care providers; or to a health care provider that is an association of three of fewer individual health care providers.

DHS is required to categorize health care providers by type and, for each type of health care provider, must annually identify the 25 conditions for which that type of provider most frequently provides services. In addition, DHS is required to prescribe the methods by which providers calculate and present median billed charges and Medicare and private third-party payments. In doing this, DHS is required to consult with organizations 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 those performance measures; (3) report results of assessments of the quality of health care services; and (4) share best practices of organizations that provide health care services.

Hospital Disclosure of Charges

Each hospital is required to prepare a single document that lists the following charge information, assuming no medical complications, for inpatient care for each of 75 diagnosis-related groups (DRGs) and the following charge information for each of 75 outpatient surgical procedures: (1) the median billed charge; (2) the average allowable payment under Medicare; and (3) the average allowable payment from private, third-party payers. The entity under contract with the state for collection, analysis, and dissemination of hospital information (the Wisconsin Hospital Association Information Center) is required to identify annually the 75 DRGs for which Wisconsin hospitals most frequently provide inpatient care and the 75 outpatient surgical procedures most frequently performed by Wisconsin hospitals.

A hospital is required to provide a health care consumer with a copy of the above document upon request at no cost to the consumer. Hospitals must update the document every calendar quarter. In addition, information included in the document does not constitute a legally binding estimate of the charge for a specific patient or the amount that a third-party payer will pay. Hospitals are required to display prominently a statement informing consumers that they have the right to receive a copy of this document and, if specified requirements are met, a good faith estimate from their insurers or governmental self-insured health plans of the person's total out-of-pocket costs according to the person's benefit terms for a specified service in the geographic region in which the service will be provided..

Health Care Provider and Hospital Disclosure Regarding Quality of Services

The Act states that a health care provider that submits data to a health care information organization must, when it provides the required information described above, make available to the consumer any public information reported by the health care information organization regarding the quality of services of that provider compared to the quality of services of other providers that is relevant to the service, diagnostic tests, or procedures specified by the consumer. The terms "health care information organization" and "public information" are defined in the Act. A health care provider may make this information available by providing the consumer a paper copy of the information or by providing the consumer with the address of an Internet site where the information is posted. If the provider submits data to more than one organization and more than one of the organizations reports to the provider public information on comparative quality, the provider must make available public information reported by only one of the organizations.

With respect to health care providers that provide information described above for 25 conditions, and with respect to hospitals that provide information for inpatient care for 75 DRGs and 75 outpatient surgical procedures, the provider or hospital must make available with the list any public information reported by the health care information organization regarding the quality of services of that provider or hospital compared to the quality of services of other providers or hospitals that is relevant. This may be done either by attaching the information to the list or by including with the list the address of an Internet site where the information is posted. If information is submitted to more than one organization and more than one organization reports to the provider or hospital public information on comparative quality, the provider or hospital is required to make available public information reported by only one of the organizations.

Penalty

Whoever violates any of the requirements above for health care providers or hospitals may be required to forfeit not more than $250 for each violation. DHS is given the authority to directly assess forfeitures and a procedure for assessing and contesting forfeitures is set forth in the Act.

Insurers

Health insurers and governmental self-insured health plans are required, on request, to provide a good faith estimate of the insured person's total out-of-pocket costs according to the person's benefit terms for a specified service in the geographic region in which the service will be provided. The good faith estimate must be an estimate as of the date of the request and assuming no medical complications or modifications in the person's treatment plan. The estimate is not a legally binding estimate of the out-of-pocket costs. The insured person may not be charged for the estimate.

Before providing this information, the insurer or governmental self-insured health plan may require the insured person 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; (5) the codes for the service under the Current Procedural Terminology or Current Dental Terminology.

The requirement on insurers does not apply if the health care provider providing the service is either a health care provider that practices individually or in association with not more than two other individual health care providers; or is a health care provider that is an association of three or fewer individual health care providers.

Effective date: The Act takes effect on January 1, 2011.

Prepared by: Richard Sweet, Senior Staff Attorney March 12, 2010 (Revised March 18, 2010)

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