

State of Wisconsin



2009 Assembly Bill 614

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2009 WISCONSIN ACT 146

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.

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.

(br) "Health care information organization" means an organization that gathers data from health care providers or hospitals regarding utilization and quality of health care services and that produces reports on the comparative quality of health care services provided by health care providers or hospitals.

* Section 991.11, WISCONSIN STATUTES 2007-08 : Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

(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](#).

(g) "Public information" means information that any person may access from a health care information organization, regardless of whether the organization charges a fee for the information.

(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.

(am) A health care provider that submits data to a health care information organization shall, when it makes a disclosure to a consumer under par. (a), make available to the consumer any public information reported by the health care information organization regarding the quality of health care services provided by the health care provider compared to the quality of health care services provided by other health care providers that is relevant to the health care service, diagnostic test, or procedure specified by the consumer under par. (a). A health care provider may make the information available to the consumer by providing the consumer a paper copy of the information or by providing the consumer the address of an Internet site where the information is posted. If the health care provider submits data to more than one health care information organization and more than one of the health care information organizations reports to the health care provider public information on comparative quality that is relevant to the health care service, diagnostic test, or procedure, the health care provider is required under this paragraph to make available to the consumer public information reported by only one of the health care information organizations.

(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.

(bm) A health care provider that submits data to a health care information organization shall make available with the document required under par. (b) any public information reported by the health care information organization regarding the quality of health care services provided by the health care provider compared to the quality of health care services provided by other health care providers that is relevant to a presenting condition for which the provider is required to list charge information under par. (b). A health care provider may make the information available by attaching it to the document or by including the address of an Internet site where the information is posted with the document. If the health care provider submits data to more than one health care information organization and more than one of the health care

information organizations reports to the health care provider public information on comparative quality that is relevant to a presenting condition, the health care provider is required under this paragraph to make available public information reported by only one of the health care information organizations for the presenting condition.

(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) and the information described under par. (bm).

(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) and, if applicable, the information described under par. (bm), 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.

(am) A hospital that submits data to a health care information organization shall make available with the document required under par. (a) any public information reported by the health care information organization regarding the quality of health care services provided by

the hospital compared to the quality of health care services provided by other hospitals that is relevant to a diagnosis related group or outpatient surgical procedure for which the hospital is required to list charge information under par. (a). A hospital may make the information available by attaching it to the document or by including the address of an Internet site where the information is posted with the document. If a hospital submits data to more than one health care information organization and more than one of the health care information organizations reports to the hospital public information on comparative quality that is relevant to a diagnosis related group or outpatient surgical procedure, the hospital is required under this paragraph to make available public information reported by only one of the health care information organizations for the diagnosis related group or outpatient surgical procedure.

(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) and the information described under par. (am).

(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) and, if applicable, the information described under par. (am), 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:

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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.
