



**ASSEMBLY SUBSTITUTE AMENDMENT 1,
TO 2007 ASSEMBLY BILL 729**

February 11, 2008 - Offered by Representative WIECKERT.

1 **AN ACT** *to amend* 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t)
2 and 185.983 (1) (intro.); and *to create* 146.903, 609.71 and 632.798 of the
3 statutes; **relating to:** disclosure of information by health care providers and
4 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 patients of the health care providers with certain charge information, upon request by and at no cost to the patients; 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 patient's request, provide the patient with the median billed charges (as defined in the substitute amendment), assuming no complications, and the appropriate Current Procedural Terminology code of the American Medical Association (CPT code), for inpatient or outpatient health care services, diagnostic tests, or procedures provided by the health care provider that the patient specifies. In addition, upon request, the health care provider must immediately, on site, provide the patient with 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.

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 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 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 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, the provider's estimate of the charges, and the CPT code or Current Dental Terminology code for the service. 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 patients of the health care providers of the patients' right to request charge 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:

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

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

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

3 40.51 **(8m)** Every health care coverage plan offered by the group insurance
4 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
5 632.748, ~~632.798~~, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (15).

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

8 66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
9 a village provides health care benefits under its home rule power, or if a town
10 provides health care benefits, to its officers and employees on a self-insured basis,
11 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
12 632.746 (10) (a) 2. and (b) 2., 632.747 (3), ~~632.798~~, 632.85, 632.853, 632.855, 632.87
13 (4) ~~and~~, (5), ~~and~~ (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

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

16 120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss.
17 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
18 ~~632.798~~, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), ~~and~~ (6), 632.895 (9) to (15),
19 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

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

21 **146.903 Disclosures required of health care providers.** (1) In this
22 section:

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

1 (b) “Ambulatory surgery center” has the meaning given in 42 CFR 416.2.

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

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

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

9 (f) “Median billed charge” means the amount that a health care provider
10 charged for a health care service, diagnostic test, or procedure, before any discount
11 or contractual rate applicable to certain patients or payers was applied, during the
12 first 2 calendar quarters of the most recently completed calendar year, as calculated
13 by arranging the charges in that reporting period from highest to lowest and
14 selecting the middle charge in the sequence or, for an even number of charges,
15 selecting the 2 middle charges in the sequence and calculating the average of the 2.

16 (g) “Medical Assistance” means health care benefits provided under subch. IV
17 of ch. 49.

18 **(2)** Except as provided in sub. (5), a health care provider or the health care
19 provider’s designee shall, upon request by and at no cost to an individual patient of
20 the health care provider, for the patient’s own use, disclose to the patient all of the
21 following, under the following circumstances:

22 (a) Within a reasonable period of time after the request, for an inpatient or
23 outpatient health care service, diagnostic test, or procedure that is specified by the
24 patient and that is provided by the health care provider, all of the following:

25 1. The median billed charge, assuming no medical complications.

1 2. The appropriate code under the Current Procedural Terminology of the
2 American Medical Association.

3 (b) Immediately upon request, on the site of the health care provider, the
4 median billed charge, assuming no medical complications, for each of 25 health care
5 services, diagnostic tests, or procedures, relevant to the treatment of particular
6 presenting conditions, as specified annually by the department based on claims data
7 under Medical Assistance from the most recently-completed fiscal year. The
8 information under this paragraph shall be classified as follows:

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

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

13 3. If provided by a physician, under a classification of physician specialties
14 that is specified by the department, by presenting conditions, including the total
15 charges for codes under the Current Procedural Terminology of the American
16 Medical Association that are most frequently performed as a result of the presenting
17 conditions. "Presenting conditions" under this subdivision shall be defined by the
18 department after consulting with the Wisconsin Collaborative for Healthcare
19 Quality.

20 4. If provided by a health care provider other than a hospital or physician, by
21 a grouping form similar to that under subd. 1., 2., or 3. Notwithstanding the
22 requirement under par. (b) (intro.) that 25 health care services, diagnostic tests, or
23 procedures be disclosed, if the health care provider under this subdivision performs
24 fewer than 25 health care services, diagnostic tests, or procedures on a regular basis,
25 the health care provider shall indicate that fact and disclose those health care

1 services, diagnostic tests, or procedures that the health care provider performs on a
2 regular basis.

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

6 (4) Except as provided in sub. (5), a health care provider shall prominently
7 display, in the area of the health care provider's practice or facility that is most
8 commonly frequented by patients, a statement informing the patients that they have
9 the right to request charge information for health care services, diagnostic tests, or
10 procedures from the health care provider or, if the requirements under s. 632.798 (2)
11 (d) are met, a good faith estimate, from their insurers or self-insured health plans,
12 of the insured's total out-of-pocket cost according to the insured's benefit terms for
13 the specified health care service in the geographic region in which the health care
14 service will be provided.

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

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

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

20 (6) (a) Whoever violates this section may be required to forfeit not more than
21 \$500 for each violation.

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

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

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

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

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

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

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

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

9 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be
10 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
11 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
12 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,
13 632.853, 632.855, 632.87 (2m), (3), (4), and (5), and (6), 632.895 (5) and (9) to (15),
14 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring
15 association shall:

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

17 **609.71 Disclosure of out-of-pocket costs.** Limited service health
18 organizations, preferred provider plans, and defined network plans are subject to s.
19 632.798.

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

21 **632.798 Disclosure of out-of-pocket costs. (1) DEFINITIONS.** In this
22 section:

23 (a) “Disability insurance policy” has the meaning given in s. 632.895 (1) (a).

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

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

3 **(2) PROVIDE ESTIMATE.** (a) A self-insured health plan or an insurer that
4 provides coverage under a disability insurance policy shall, at the request of an
5 insured, provide to the insured a good faith estimate, as of the date of the request and
6 assuming no medical complications or modifications to the treatment plan, of the
7 insured's total out-of-pocket cost according to the insured's benefit terms for a
8 specified health care service in the geographic region in which the health care service
9 will be provided.

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

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

14 (d) Before providing the information requested under par. (a), the insurer or
15 self-insured health plan may require the insured to provide any of the following
16 information:

- 17 1. The name of the provider providing the service.
- 18 2. The facility at which the service will be provided.
- 19 3. The date the service will be provided.
- 20 4. The provider's estimate of the charge for the service.
- 21 5. The code for the service under the Current Procedural Terminology of the
22 American Medical Association or under the Current Dental Terminology of the
23 American Dental Association.

24 **SECTION 10. Initial applicability.**

