



State of Wisconsin
2007 - 2008 LEGISLATURE

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**ASSEMBLY SUBSTITUTE AMENDMENT 1,
TO 2007 ASSEMBLY BILL 872**

March 5, 2008 – Offered by Representative RICHARDS.

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 health care consumers with certain charge or payment rate information, upon request by and at no cost to the consumers; 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 consumer's request, provide the consumer with the median billed charges (as defined in the substitute amendment), assuming no complications, for inpatient or outpatient health care services, diagnostic tests, or procedures provided by the health care provider that the consumer specifies. In addition, upon request, the health care provider must immediately, on site, provide the consumer with all of the following information, as a single document:

1. 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.

2. If the health care provider is certified as a provider of Medical Assistance (MA), the MA payment rates for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

3. If the health care provider is certified as a provider of Medicare, the Medicare payment rates for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

4. The average allowable payment from private, third-party payers for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

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 median reimbursement that the insurer or self-insured health plan would expect to pay for a specified health care service in the geographic region in which the service will be provided. In addition, the insurer or self-insured health plan must provide to an insured or enrollee a good faith estimate of the insured's or enrollee's total out-of-pocket cost for the specified service. 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 any of 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, and the provider's estimate of the charges. However, the insurer or self-insured health plan may not require the insured or enrollee to provide the Current Procedural Terminology code or Current Dental Terminology code for the service as a condition of providing the information. 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 health care consumers of the consumers' right to

request charge or payment rate 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.

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

9 40.51 (8m) Every health care coverage plan offered by the group insurance
10 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
11 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (15).

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

14 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
15 a village provides health care benefits under its home rule power, or if a town
16 provides health care benefits, to its officers and employees on a self-insured basis,
17 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
18 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87
19 (4) ~~and~~, (5), and (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

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

1 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
2 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
3 632.798, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), ~~and (6)~~, 632.895 (9) to (15),
4 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

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

6 **146.903 Disclosures required of health care providers.** (1) In this
7 section:

8 (a) “All-patient refined diagnosis-related groups” means a system of
9 classifying inpatient hospital discharges that applies to patients of any age and
10 distinguishes among 4 levels of severity of illness within each classification.

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

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

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

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

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

1 (g) "Medical Assistance" means health care benefits provided under subch. IV
2 of ch. 49.

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

5 (2) Except as provided in sub. (5), a health care provider or the health care
6 provider's designee shall, upon request by and at no cost to a health care consumer,
7 disclose to the consumer all of the following, under the following circumstances:

8 (a) Within a reasonable period of time after the request, the median billed
9 charge, assuming no medical complications, for an inpatient or outpatient health
10 care service, diagnostic test, or procedure that is specified by the consumer and that
11 is provided by the health care provider.

12 (b) Immediately upon request, on the site of the health care provider, as a single
13 document, all of the following:

14 1. The median billed charge, assuming no medical complications, for each of 25
15 health care services, diagnostic tests, or procedures, relevant to the treatment of
16 particular presenting conditions, as specified annually by the department based on
17 claims data under Medical Assistance from the most recently-completed fiscal year.

18 The information under this subdivision shall be classified as follows:

19 a. If provided concerning inpatient services by a hospital, by diagnosis-related
20 groups or all-patient refined diagnosis-related groups.

21 b. If provided concerning outpatient services by a hospital, or if provided by an
22 ambulatory surgery center, by surgical procedure code.

23 c. If provided by a physician, under a classification of physician specialties that
24 is specified by the department, by presenting conditions, including the total charges
25 for codes under the Current Procedural Terminology of the American Medical

1 Association that are most frequently performed as a result of the presenting
2 conditions. “Presenting conditions” under this subd. 1. c. shall be defined by the
3 department after consulting with the Wisconsin Collaborative for Healthcare
4 Quality.

5 d. If provided by a health care provider other than a hospital or physician, by
6 a grouping form similar to that under subd. 1. a., b., or c. Notwithstanding the
7 requirement under subd. 1. (intro.) that 25 health care services, diagnostic tests, or
8 procedures be disclosed, if the health care provider under this subd. 1. d. performs
9 fewer than 25 health care services, diagnostic tests, or procedures on a regular basis,
10 the health care provider shall indicate that fact and disclose those health care
11 services, diagnostic tests, or procedures that the health care provider performs on a
12 regular basis.

13 2. If the health care provider is certified as a provider of Medical Assistance,
14 the Medical Assistance payment rates for the provider for the health care services,
15 diagnostic tests, or procedures specified in subd. 1.

16 3. If the health care provider is certified as a provider of Medicare, the Medicare
17 payment rates for the provider for the health care services, diagnostic tests, or
18 procedures specified in subd. 1.

19 4. The average allowable payment from private, 3rd-party payers for the
20 health care services, diagnostic tests, or procedures specified in subd. 1.

21 **(3)** Information on charges or payment rates that is provided to a health care
22 consumer under sub. (2) shall be updated annually by the health care provider and
23 may not be construed as a legally binding estimate of the cost to the consumer.

24 **(4)** Except as provided in sub. (5), a health care provider shall prominently
25 display, in the area of the health care provider’s practice or facility that is most

1 commonly frequented by health care consumers, a statement informing the
2 consumers that they have the right to request charge or payment rate information
3 for health care services, diagnostic tests, or procedures from the health care provider
4 or, if the requirements under s. 632.798 (2) (e) are met, all of the following from their
5 insurers or self-insured health plans:

6 (a) A good faith estimate of the median reimbursement that the insurer or
7 self-insured health plan would expect to pay for a specified health care service in the
8 geographic region in which the health care service will be provided.

9 (b) A good faith estimate of the insured's total out-of-pocket cost according to
10 the insured's benefit terms for the specified health care service in the geographic
11 region in which the health care service will be provided.

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

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

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

17 **(6)** (a) Whoever violates this section may be required to forfeit not more than
18 \$500 for each violation.

19 (b) The department may directly assess forfeitures provided for under par. (a).
20 If the department determines that a forfeiture should be assessed for a particular
21 violation, the department shall send a notice of assessment to the alleged violator.
22 The notice shall specify the amount of the forfeiture assessed, the violation, and the
23 statute or rule alleged to have been violated, and shall inform the alleged violator of
24 the right to a hearing under par. (c).

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

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

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

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

1 185.981 ~~(4t)~~ A sickness care plan operated by a cooperative association is
2 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798,
3 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and (5)~~, and (6), 632.895 (10) to (15),
4 and 632.897 (10) and chs. 149 and 155.

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

7 185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be
8 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
9 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
10 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,
11 632.853, 632.855, 632.87 (2m), (3), (4), ~~and (5)~~, and (6), 632.895 (5) and (9) to (15),
12 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring
13 association shall:

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

15 **609.71 Disclosure of payments.** Limited service health organizations,
16 preferred provider plans, and defined network plans are subject to s. 632.798.

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

18 **632.798 Disclosure of payments. (1) DEFINITIONS.** In this section:

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

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

22 (c) “Self-insured health plan” means a self-insured health plan of the state or
23 a county, city, village, town, or school district.

24 **(2) PROVIDE INFORMATION.** (a) A self-insured health plan or an insurer that
25 provides coverage under a disability insurance policy shall, at the request of an

1 insured, provide to the insured a good faith estimate of the median reimbursement
2 that the insurer or self-insured health plan would expect to pay for a specified health
3 care service in the geographic region in which the health care service will be
4 provided.

5 (b) If requested by the insured, the insurer or self-insured health plan under
6 par. (a) shall also provide to the insured a good faith estimate, as of the date of the
7 request, of the insured's total out-of-pocket cost according to the insured's benefit
8 terms for the specified health care service in the geographic region in which the
9 health care service will be provided.

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

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

14 (e) 1. Before providing any of the information requested under par. (a) or (b),
15 the insurer or self-insured health plan may require the insured to provide any of the
16 following information:

17 a. The name of the provider providing the service.

18 b. The facility at which the service will be provided.

19 c. The date the service will be provided.

20 d. The provider's estimate of the charge for the service.

21 2. The insurer or self-insured health plan may not require an insured to
22 provide the code for the service under the Current Procedural Terminology of the
23 American Medical Association or under the Current Dental Terminology of the
24 American Dental Association as a condition for providing the information requested
25 under par. (a) or (b).

1 **SECTION 10. Initial applicability.**

2 (1) DISCLOSURE OF CHARGES, PAYMENTS, AND OUT-OF-POCKET COSTS. If a disability
3 insurance policy or a governmental self-insured health plan that is in effect on the
4 effective date of this subsection, or a contract or agreement between a provider and
5 a health care plan that is in effect on the effective date of this subsection, contains
6 a provision that is inconsistent with this act, this act first applies to that disability
7 insurance policy, governmental self-insured health plan, or contract or agreement
8 on the date on which it is modified, extended, or renewed.

9 **SECTION 11. Effective date.**

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

12

(END)