State of Wisconsin
2009 – 2010 LEGISLATURE

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ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO 2009 ASSEMBLY BILL 207

October 20, 2009 – Offered by Representative BENEDICT.

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 146.97, 609.895 and 632.792 of the statutes; **relating to:** requiring that patients be informed of any health care facility use charge and that the charge be identified and requiring disclosure of insurance coverage of facility use charge.

Analysis by the Legislative Reference Bureau

This substitute amendment requires a health care facility or health care provider that itemizes a charge for use of the facility to notify a patient, orally at the time the appointment is made, that it will impose the facility use charge. Before the end of the next business day after the appointment is made, the health care facility or health care provider must provide the patient with a good faith estimate of the facility use charge. The health care facility or health care provider on any bill imposing the charge, must identify the facility use charge as a "facility fee" but may charge a facility use charge different from the amount given in the good faith estimate.

Beginning on January 1, 2011, this substitute amendment also requires health insurance policies and self–insured governmental and school district health plans to disclose in a policy, plan, or certificate of coverage all of the following regarding the facility use charge: whether the policy or plan covers a health care facility use charge

and to what extent the charge is covered, whether the policy or plan imposes limitations on the coverage of the facility use charge, and whether a patient's payment of all or part of the facility use charge counts toward any deductible under the policy or plan. The disclosure requirement applies to individual and group health insurance policies, including limited service health organizations, preferred provider plans, defined network plans, and cooperative sickness care associations; to health care plans, including a self–insured plan, offered by the state to its employees; and to self–insured health plans of a city, town, village, county, or school district.

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, 632.792, 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, 632.792, 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), 632.792, 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), 632.792, 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. 146.97 of the statutes is created to read:

146.97 Health care facility use charges. (1) In this section:

(a) "Clinic" means a place that is used primarily for the provision of services of a health care provider.

(b) "Health care facility" has the meaning given in s. 146.997 (1) (c) and includes a clinic and an ambulatory surgery center, as defined in s. 153.01 (1g).

(c) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (k).

(2) If a health care facility or a health care provider itemizes a billing charge for use of the health care facility during a patient's office visit with a health care provider, the health care facility or health care provider shall do all of the following:

(a) At the time the appointment is made, notify the patient orally that the health care facility use charge will be imposed and that the patient should check with his or her insurer to determine whether the insurer covers that charge.

(b) Before the end of the next business day after the day on which the appointment is made, provide the patient with a good faith estimate of the facility use charge either as a specific dollar amount or as a dollar range that includes at least

80 percent of the health care facility's or health care provider's facility use charges over a 12–month period that ended within 6 months before the date of the estimate. An estimate that is placed in the mail before the end of the next business day is provided within the time required under this paragraph.

(c) Identify in any bill for the office visit the health care facility use charge as a "facility fee."

(3) The facility or the provider may charge to the patient an actual facility use charge that is different from the good faith estimate of the facility use charge provided under sub. (2) (b).

SECTION 6. 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, 632.792, 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 7. 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, 632.792, 632.795, 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 8. 609.895 of the statutes is created to read:

609.895 Disclosure of facility use charge coverage. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.792.

SECTION 9. 632.792 of the statutes is created to read:

632.792 Disclosure of facility use charge coverage. (1) DEFINITIONS. In this section:

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

(b) "Health care facility" has the meaning given in s. 146.97 (1) (b).

(c) "Health care facility use charge" means an itemized billing charge by a health care facility or health care provider for use of the health care facility during a patient's office visit with a health care provider.

(d) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (k).

(e) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) REQUIRED DISCLOSURE. Every disability insurance policy and every self–insured health plan shall disclose of all of the following in any policy, plan, or certificate of coverage:

(a) Whether the policy or plan covers a health care facility use charge.

(b) The extent of, and limitations on, coverage of a health care facility use charge.

(c) Whether a patient's payment for all or part of a health care facility use charge counts toward satisfying any deductible amount under the policy or plan.

SECTION 10. Initial applicability.

(1) The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.895, and 632.792 of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and governmental or school district self–insured health plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Governmental or school district self–insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

SECTION 11. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.895, and 632.792 of the statutes and SECTION 10 of this act take effect on January 1, 2011.

(END)