State of Wisconsin
2009 – 2010 LEGISLATURE

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ASSEMBLY SUBSTITUTE AMENDMENT 2,

TO 2009 ASSEMBLY BILL 207

February 8, 2010 – 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 charge for clinic services and requiring disclosure of insurance coverage of a charge for clinic services.

Analysis by the Legislative Reference Bureau

This substitute amendment requires a health care facility or health care provider that itemizes a charge for clinic services to notify a patient that it may impose the charge for clinic services in addition to the charge for services provided by the health care provider during a health care facility visit. The health care facility or health care provider must make the notification orally at the time the appointment is made if the patient makes the appointment in person or by telephone and electronically or in writing within 24 hours after the appointment is made if the patient makes the appointment electronically. Upon request of the patient, the health care facility or health care provider must provide the patient with a good faith estimate of the charge for clinic services before the end of the second business day after the day the patient makes the request for the estimate. On any bill imposing the charge, the health care facility or health care provider must identify the charge

as a "charge for clinic services" but may charge an amount different from the amount given in a good faith estimate. A health care facility or health care provider is not required to make the notification that a charge for clinic services may be imposed if either 1) the health care facility or health care provider provided the notification within the 12 months before the appointment is requested for a health care facility visit for the same services or 2) the health care facility or health care provider previously provided the notification and the patient had a health care facility visit for the same services within the 12 months before the appointment is requested.

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 charge for clinic services: whether the policy or plan covers a charge for clinic services and to what extent the charge is covered, whether the policy or plan imposes limitations on the coverage of the charge for clinic services, and whether a patient's payment of all or part of the charge for clinic services 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 Charges for clinic services. (1) In this section:

(a) "Charge for clinic services" means a billing charge by a health care facility or a health care provider for use of the health care facility during a patient's health care facility visit with a health care provider indicated by a billing code for clinic services under the Healthcare Common Procedure Coding System, as described in 45 CFR 162.1002.

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

(c) "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).

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

(2) Except as provided in sub. (3), if a health care facility or a health care provider itemizes on a bill a charge for clinic services, the health care facility or health care provider shall do all of the following:

(a) 1. If a patient makes an appointment for a health care facility visit in person or over the telephone, notify the patient orally at the time the appointment is made that the patient may receive, in addition to a charge for the services provided by the health care provider during the visit, a charge for clinic services, which may be on a separate bill.

2. If a patient makes an appointment for a health care facility visit electronically, notify the patient electronically or in writing within 24 hours of the health care provider receiving the electronic appointment request that the patient may receive, in addition to a charge for the services provided by the health care provider during the visit, a charge for clinic services, which may be on a separate bill.

(b) Upon request of the patient and before the end of the 2nd business day after the day on which the request is made, provide the patient with a good faith estimate of the charge for clinic services.

(c) Identify in any bill for the health care facility visit the charge for clinic services as a "clinic service charge."

(3) A health care facility or health care provider is not required to provide the notification under sub. (2) (a) 1. or 2. if one of the following applies:

(a) Within the 12 months immediately preceding the patient's request for the appointment, the health care facility or health care provider provided the patient the

notification under sub. (2) (a) 1. or 2. for a health care facility visit for the same services.

(b) Before the patient requested the appointment, the health care facility or health care provider provided the patient the notification under sub. (2) (a) 1. or 2. for a health care facility visit for the same services, and the patient had a visit for the same services within the 12 months immediately preceding the patient's request for the appointment.

(4) The health care facility or the health care provider may charge to the patient an actual charge for clinic services that is different from the good faith estimate of the charge for clinic services 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 charge for clinic services 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 charge for clinic services coverage. (1) DEFINITIONS. In this section:

(a) "Charge for clinic services" has the meaning given in s. 146.97 (1) (a).

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

(c) "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 charge for clinic services.

(b) The extent of, and limitations on, coverage of a charge for clinic services.

(c) Whether a patient's payment for all or part of a charge for clinic services 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)