WISCONSIN LEGISLATIVE COUNCIL AMENDMENT MEMO

2009 Senate Bill 418	Senate Substitute Amendment 1
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2009 SENATE BILL 418

Health Care Provider Information Specific to a Consumer

The **bill** requires a health care provider[1] including a clinic and an ambulatory surgery center, or the provider's designee, to disclose, upon request to the consumer, the median billed charges,[2] assuming no medical complications, for an inpatient or outpatient health care service, diagnostic test, or procedure that is specified by the consumer and that is provided by the health care provider. This information must be provided at no cost to the consumer and within a reasonable period of time.

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[1] "Health care provider" is defined as any of the following, or a partnership, corporation, or limited liability company of any of these providers: nurse, chiropractor, dentist, physician, physician assistant, perfusionist, respiratory care practitioner, physical therapist, podiatrist, dietitian, athletic trainer, occupational therapist, occupational therapy assistant, optometrist, pharmacist, acupuncturist, psychologist, social worker, marriage and family therapist, professional counselor, speech and language pathologist, audiologist, massage therapist or bodyworker, cooperative sickness care plan directly providing services through salaried employees in its own facility, hospice, inpatient health care facility, community-based residential facility (CBRF), and rural medical center, and includes a clinic and an ambulatory surgical center.

[2] "Median billed charges" is defined as the amount that a health care provider charged for a health care service, diagnostic test, or procedure, before any discount or contractual rate applicable to certain patients or payers was applied, during the first two 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 two middle charges in the sequence and calculating the average of the two.

One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
(608) 266-1304 • Fax: (608) 266-3830 • Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc

Provider Information on Frequently Performed Services, Tests, and Procedures

The **bill** requires a health care provider to prepare a document that lists the following charge information for diagnosing and treating each of the 25 presenting conditions identified annually for the health care provider by the Department of Health Services (DHS):

- The median billed charge.
- If the health care provider is certified as a Medical Assistance (MA) provider, the MA payment to the provider.
- If the health care provider is certified by Medicare, the Medicare payment to the provider.
- The average allowable payment from private, third-party payers.

A health care provider or the provider's designee must provide this information to a health care consumer upon the consumer's request and at no cost.

In identifying this information, the DHS must use claims data for MA and must consult with the Wisconsin Collaborative for Healthcare Quality (WCHQ) in identifying the presenting conditions. The DHS must also, after consulting with WCHQ, prescribe the methods by which a health care provider must calculate and present median billed charges and MA, Medicare, and private, third-party payer payments for a presenting condition.

The **bill** requires the health care provider to annually update the information on charges and payment rates provided to a consumer. Also, this information may not be construed as a legally binding estimate of the cost to the consumer.

Display of Notice

The **bill** requires a health care provider to prominently display, in the area of the provider's practice or facility most commonly frequented by health care consumers, a statement informing consumers that they have the right to request charge information from the health care provider and all of the following from their insurers or self-insured health plans:

- 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 health care service will be provided.
- A good faith estimate 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.

The requirements outlined above do not apply to a health care provider that practices individually and not in association with another health care provider, nor do they apply to health care providers that are an association of three or fewer individual health care providers.

Forfeitures

The **bill** adds a $500 forfeiture for health care provider noncompliance with the above provisions and allows DHS to directly assess the forfeitures and provides a procedure for contesting the imposition of a forfeiture.

Insurer Information

The **bill** requires an insurer, or a self-insured health plan of the state or county, city, village, town, or school district, to provide, at the request of an insured and without charge, 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, and the 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. Neither of these are legally binding estimates, nor may the insured be charged for this information.

Insurer Requirements of an Insured

The **bill** permits an insurer to require an insured to provide the following information before responding to an insured's request for the information required under the **bill**:

- 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 charge for the service.
- The code for the service under the Current Procedural Terminology of the American Medical Association of Current Dental Terminology of the American Dental Association.

Delayed Effective Date

The **bill** has a delayed effective date of nine months.

SENATE SUBSTITUTE AMENDMENT 1

Senate Substitute Amendment 1 makes the following changes to the bill:

- Changes the definition of "health care provider" to exclude inpatient health care facilities, CBRFs, and rural medical centers. Nursing homes are also specifically excluded from the definition. Hospitals are still included but are subject to separate disclosure requirements.
- Changes the definition of "median billed charge" by creating two separate definitions of median billed charge: one that applies to health care providers, and one that applies to hospitals. The definition of median billed charge applicable to health care providers is the same as in the bill. The definition of median billed charge applicable to hospitals is "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."

- Requires DHS to categorize health care providers subject to the bill's requirements by type and identify the 25 presenting conditions for which that type of health care provider most frequently provides health care services; also requires DHS to prescribe methods by which providers must calculate and present charge and payment information.

- Deletes the requirement for the DHS to consult with the WCHQ in identifying these 25 presenting conditions. Instead, the DHS must consult with organizations in this state that do all of the following:

  - Develop performance measures for assessing the quality of health care services.

  - Guide the collection, validation, and analysis of data related to these quality measures.

  - Report results of assessments of the quality of health care services.

  - Share best practices of organizations that provide health care services.

- Provides that the document listing each of the 25 presenting conditions for the health care provider's type must list the charge information, assuming there are no medical complications. In addition, the charge information that is provided excludes the MA charges.

- Specifies that information in both the charge document or summary of the top 25 presenting conditions does not constitute a legally binding estimate of the charge for a specific patient or the amount that a third-party payer will pay on behalf of the patient. The bill only stated this for the summary document.

- Deletes the requirement that the notice that must be prominently displayed by the health care provider include "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 health care service will be provided."

- Creates a separate disclosure requirement that applies to hospitals (the bill applied the same requirement to hospitals and other health care providers). A hospital is required to 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):

  - The median billed charge.

  - The average allowable payment under Medicare.

- The average allowable payment from private, third-party payers.

- Requires a hospital to provide a copy of the summary document, at no cost, to a consumer, upon request by and at no cost to a health care consumer. The hospital must update the document every calendar quarter. The information on the document does not constitute a legally binding estimate. The hospital must display a notice that consumers have a right to receive a copy of this document. The hospital's statement must also inform consumers of the right to receive a good faith estimate from their insurer, of the insured's total out-of-pocket cost according to the insured's benefit terms for the specific health and service in the geographic region in which the service will be provided.

- Reduces the forfeiture to $250.

LEGISLATIVE HISTORY

On February 24, 2010, the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue, recommended adoption of Senate Substitute Amendment 1, and recommended the **bill** for passage, as amended, both on votes of Ayes, 7; Noes, 0.

LR:ty:jb;wu