State of Wisconsin
2009 - 2010 LEGISLATURE

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2009 ASSEMBLY BILL 614

December 11, 2009 – Introduced by Representatives Richards, Staskunas, Turner, Pope-Roberts, Hebl, Roys, A. Williams, Soletski, Hraychuck, Krusick, Hilgenberg, Milroy and Dexter, cosponsored by Senators Sullivan, Cowles, Kreitlow, Miller, Lehman and Vinehout. Referred to Committee on Health and Healthcare Reform.

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*** 146.903, 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers and insurers and providing a penalty.

Analysis by the Legislative Reference Bureau

This bill requires a health care provider to disclose to a consumer the provider's median billed charge for a health care service, diagnostic test, or procedure, upon request. The bill also requires a health care provider to disclose specified charge information for the 25 presenting conditions for which the provider most frequently provides services, as identified by the Department of Health Services (DHS). The bill requires DHS to consult with the Wisconsin Collaborative for Healthcare Quality, and to use Medical Assistance claims data, in identifying the presenting conditions for each health care provider. Under the bill, a health care provider must create a document that lists the following charge information for diagnosing and treating each of the 25 presenting conditions identified by DHS for the provider: 1) the provider's median billed charges; 2) the reimbursement amount under Medical Assistance, if the health care provider participates in the Medical Assistance Program; 3) the reimbursement amount under Medicare, if the provider participates in Medicare; and 4) the average allowable payment from private, third–party payers. A health care provider must update the document annually.

Under the bill, these provisions relating to disclosing charge information apply to health care facilities such as a hospital, ambulatory surgical center, or nursing home, and to associations of health care provides that include four or more practitioners.

Under the bill, 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, the provider's estimate of the charges, and the Current Procedural Terminology code or Current Dental Terminology code for the service. In addition, the bill provides that any good faith estimate provided is not a legally binding estimate.

The bill also requires health care providers to display prominently statements informing health care consumers of the consumers' right to receive charge information from the health care providers and from their insurers.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

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, <u>632.798,</u> 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, 632.798, 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), 632.798, 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), 632.798, 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. 146.903 of the statutes is created to read:

146.903 Disclosures required of health care providers. (1) DEFINITIONS. In this section:

(a) "Ambulatory surgical center" has the meaning given in 42 CFR 416.2.

(b) "Clinic" means a place, other than a residence, that is used primarily for the provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and treatment.

(c) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (p) and includes a clinic and an ambulatory surgical center.

(d) "Median billed charge" means 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 2 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 2 middle charges in the sequence and calculating the average of the 2.

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

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

(2) DEPARTMENT DUTIES. (a) The department shall, for each health care provider that is required to comply with sub. (4), annually identify the 25 presenting conditions for which the health care provider most frequently provides health care services. The department shall use claims data for Medical Assistance and shall consult with the Wisconsin Collaborative for Healthcare Quality in identifying the presenting conditions.

(b) The department shall, after consulting with the Wisconsin Collaborative for Healthcare Quality, prescribe the methods by which a health care provider shall calculate and present median billed charges and Medical Assistance, Medicare, and private, 3rd–party payer payments for a presenting condition under this section.

(3) CHARGE FOR A SERVICE. Except as provided in sub. (6), a health care provider or the health care provider's designee shall, upon request by and at no cost to a health care consumer, disclose to the consumer within a reasonable period of time after the request, the median billed charge, 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.

(4) SUMMARY OF CHARGES FOR COMMON SERVICES. (a) Except as provided in sub. (6), a health care provider shall prepare a single document that lists the following charge information for diagnosing and treating each of the 25 presenting conditions identified for the health care provider under sub. (2):

1. The median billed charges.

2. If the health care provider is certified as a provider of Medical Assistance, the Medical Assistance payment to the provider.

3. If the health care provider is certified as a provider of Medicare, the Medicare payment to the provider.

4. The average allowable payment from private, 3rd–party payers.

(b) Except as provided in sub. (6), a health care provider or the health care provider's designee shall, upon request by and at no cost to a health care consumer, provide the consumer a copy of the document prepared under par. (a).

(c) A health care provider shall annually update the document under par. (a).

(d) Charge information included on the document under par. (a) does not constitute a legally binding estimate of the cost to the consumer.

(5) NOTICE. Except as provided in sub. (6), a health care provider shall prominently display, in the area of the health care provider's practice or facility that is most commonly frequented by health care consumers, a statement informing the consumers that they have the right to receive charge information as provided in subs.

(3) and (4) from the health care provider and, if the requirements under s. 632.798 (2) (e) are met, all of the following from their insurers or self–insured health plans:

(a) 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.

(b) 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.

(6) APPLICABILITY TO HEALTH CARE PROVIDERS. The requirements under subs. (3) to (5) do not apply to any of the following:

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

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

(7) PENALTY. (a) Whoever violates this section may be required to forfeit not more than $500 for each violation.

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

(c) An alleged violator may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (b), a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1).

The administrator of the division may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator of the division shall be the final administrative decision. The division shall commence the hearing within 30 days after receipt of the request for a hearing and shall issue a final decision within 15 days after the close of the hearing. Proceedings before the division are governed by ch. 227. In any petition for judicial review of a decision by the division, the party, other than the petitioner, who was in the proceeding before the division shall be the named respondent.

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

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

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, <u>632.798,</u> 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, 632.795, <u>632.798,</u> 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. 609.71 of the statutes is created to read:

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

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

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

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

(b) "Insured" includes an enrollee under a self–insured health plan and a representative or designee of an insured or enrollee.

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

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

(b) If requested by the insured, the insurer or self–insured health plan under par. (a) shall also provide to the insured a good faith estimate, as of the date of the request, 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.

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

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

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

1. The name of the provider providing the service.

2. The facility at which the service will be provided.

3. The date the service will be provided.

4. The provider's estimate of the charge for the service.

5. The code for the service under the Current Procedural Terminology of the American Medical Association or under the Current Dental Terminology of the American Dental Association.

SECTION 10. Initial applicability.

(1) DISCLOSURE OF CHARGES, PAYMENTS, AND OUT–OF–POCKET COSTS. If a disability insurance policy or a governmental self–insured health plan that is in effect on the effective date of this subsection, or a contract or agreement between a provider and a health care plan that is in effect on the effective date of this subsection, contains a provision that is inconsistent with this act, this act first applies to that disability

insurance policy, governmental self–insured health plan, or contract or agreement on the date on which it is modified, extended, or renewed.

SECTION 11. Effective date.

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

(END)