Model State Health Care Price Transparency Legislation

INTRODUCTION

In March 2013, the Health Care Incentives Improvement Institute and Catalyst for Payment Reform issued a report card[1] ranking each state in the US on the availability and accessibility of health care services pricing. The results of that report card showed that, generally, most residents in the large majority of states do not have access to pricing information on health care services.

This report was released on the heels of a TIME cover story on the price of health care and has been followed by several other news stories highlighting the significant variability in the prices of health care within a defined geography, and the inability for consumers to know, up front, what a service will cost.

With an ever-larger proportion of consumers in health plans with large deductibles and high co-insurance, the importance of pricing information is growing. Consumers are awarded certain protections with respect to pricing information for almost all purchases other than health care.

The purpose of the attached draft legislation is to provide state lawmakers with a starting point for enacting legislation that would meet the needs of the different stakeholders in their State, including consumers, employers, health plans, and referring practitioners. The draft legislation essentially has three components.

First in Section 2, the model bill requires the establishment of a public database on health care price and quality, primarily by instituting an all-payer claims database (APCD). A number of states are mandating APCDs that are designed to publish historical prices for a basket of routine or common procedures. The data generated by the APCDs enable consumers to understand, prior to having such a procedure, the estimated price and how it could vary by health care provider.[2] This type of comparative pricing information has been in practice in New Hampshire for several years. Many consumers only have catastrophic coverage or might be self-pay or uninsured, and as such would not get this information from their health plans. Further, physicians have patients with coverage from myriad health plans and such a public resource could become a useful look-up to help guide price-conscious patients in comparing facilities and practitioners. APCDs are also being used to monitor public health issues, provide insights on price disparities and quality issues, and many other health policies of interest to state officials.

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[1] See www.hci3.org/content/report-card-state-price-transparency-laws

[2] See http://www.apcdcouncil.org/standards for standards on data elements recommended for inclusion in an APCD.

Section 3 addresses the need of the general public for directionally accurate information on the price of health care services in a State if individual consumers are self-insured or uninsured or if they are insured through a health plan but contemplating going out-of-network for services. Some of that information can come from a hospital or practitioner when dealing with a direct inquiry from a consumer. This will ensure that all consumers are provided charging information from a provider of health care services up front, not after the fact.

Section 4 requires health plans to be responsible for providing estimated out-of-pocket expenses for common inpatient discharges and outpatient procedures (e.g. a knee ligament repair), not simply specific services (e.g. a blood test or X-ray). Recent legislation and regulations in states such as Massachusetts and Rhode Island are mandating that health plans communicate estimated out-of-pocket expenses and quality data for plan members. This is important because there are many services involved in a medical event and without an estimate from the health plan on the cost of the full event, there is virtually no way for consumers to put the pieces together and understand their potential financial liability. Health plans are also obligated to give their plan members information on quality of care based on recognized national quality standards[3].

Taken together, the model bill should provide those who are insured by commercial insurers and Medicaid, as well as the uninsured, employers, and policymakers, access to pricing and quality information on health care services in their state.

[3]See http://www.qualityforum.org/map/.

Section 1: Objective.

The purpose of this legislation is to provide greater transparency regarding health care costs and quality so that consumers, employers, providers, policymakers, and others can make more informed decisions in purchasing and making referrals for health care services.

Section 2: Creation of Public Database on Health Care Prices and Quality

(a) Agreement Between Departments of Insurance and Health. The State Department of Insurance and State Department of Health shall enter into a cooperative agreement to develop a comprehensive health care price and quality information database to provide such data in an understandable format that will then be made available to the public. The objective of the database shall be to provide information to consumers, employers, providers, and others about the quality of health care services, the price paid by consumers and insurers for health care services, and the provider cost of these services in order to improve the quality and affordability of health care and health care coverage and to allow price and quality comparisons among various treatment settings and providers.

(b) All Payer Claims Database. The data shall include health care information collected as part of an all-payer claims database. Beginning on _____ [date] and continuing thereafter in accordance with a schedule and detailed format issued through joint regulations from the Departments of Insurance and Health, each health plan and health care claims processor [covering at least ___ residents of this State], including insurers providing health care benefits through the Medicaid and Medicare programs, shall provide to the Departments of Insurance and Health, or their designee, a completed health care claims data set with actual amounts billed by providers and allowed amounts paid by the health plan for all the residents of the State who receive health care items and services, including claims for hospital and medical services, ambulatory surgical center services, drugs, durable medical equipment, medical devices, vision, and dental services. Data submission requirements shall be promulgated through regulations issued by the Departments of Insurance and Health on or before _____ [date] to carry out the purposes of this section.

(c) Lists of Services and Frequent Admissions and Procedures. The State Department of Insurance and the State Department of Health shall together develop a list of the 100 most frequently provided inpatient discharges and 100 of the most frequently provided outpatient procedures by _____ [date]. This list, at the discretion of the Departments of Insurance and Health, may include bundled episodes of care rather than individual procedures or services; provided that what is and is not included in the bundled episodes of care is very clearly described. Further, this list, which may include bundled episodes of care or individual procedures or services, shall be revised annually to reflect potential changes in

volume of procedures. In addition to these common bundles or procedures, the list shall include all outpatient services, including but not limited to durable medical equipment, and pharmacy.

(d) Range of Actual and Allowable Amounts. All health plans and third-party administrators licensed by the State must develop and furnish to the Departments of Insurance and Health by ____ [date] the range of actual and allowable amounts paid to facilities and practitioners in the health plan's network for each admission, procedure or service listed under paragraph 2(c), including the lowest, 25th, 50th, 75th, and highest percentiles. The Departments of Insurance and Health shall make this information available to the public, along with information regarding the amount allowed by Medicare for each of the admissions, procedures and services listed under paragraph 2(c).

(e) HIPAA Requirements. The collection, storage, and release of health care data that is subject to the Health Insurance Portability and Accountability Act (HIPAA) shall be governed by rules adopted in 45 CFR Parts 160 & 164 [and any State rules]. The health care information shall be encrypted such that in no event shall personal identifiable information be disclosed.

(f) Prohibition on Gag Clauses. Clauses in agreements that prevent practitioners, facilities, or health plans from disclosing negotiated price information, such as total and out-of-pocket payment information, where such price-related information is used for patient and purchaser decision-making shall be null and void and unenforceable as contrary to public policy.

(g) Advisory Working Group. A working group shall be established by and to advise the Departments of Insurance and Health regarding the collection, storage, and release of health care information under this legislation, which shall include two representatives each from the Departments of Insurance and Health and one representative from each of the following groups (i) consumers; (ii) employers; (iii) health plans; (iv) physicians; (v) hospitals; and (vi) freestanding surgical or imaging facilities. At the direction of the Departments, the Advisory Group will be convened at least once but no more than four times a year.

(h) Quality Data. The State Department of Health shall determine quality measures that health plans and third-party administrators must include when providing information to subscribers on the price and out-of-pocket costs of services provided by facilities and/or practitioners, as well as determine which quality measures should be reported to the State Departments of Insurance and Health for their database. A starter set of measures should be informed by, at least, the measures recommended by the National Quality Forum's Measures Application Partnership and the National Priorities Partnership.

Section 3: Provision of Actual Charge Estimates to Certain Consumers by Facilities and Practitioner

All health care facilities and practitioners licensed by the State shall respond with an estimate within three working days to a consumer inquiry about the actual charges for a specific admission, procedure or service when the consumer is self-pay, uninsured or insured through a health plan but the facility or practitioner is out-of-network; provided, however, that nothing in this section shall prevent the facility or practitioner from charging for unforeseen services that arise out of the proposed admission, procedure or service; and provided further, that the facility or practitioner shall alert the consumer that the actual amount the consumer might be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service. Further, the facility shall notify the consumer as to whether it is a part of the consumer's health plan's network, to the extent the consumer is insured.

Section 4: Disclosure of Quality and Cost-Sharing Data To Plan Subscribers

(a) Estimates of In-Network Out-of-Pocket Costs. All health plans and third-party administrators shall establish [for the admissions, procedures or services established by paragraph 2(c), if a State decides to limit the estimates to these 100 admissions and outpatient procedures or services], a website, mobile application, and toll-free number that enables the subscriber to request and obtain from the subscriber's health plan or third-party administrator (1) the allowed payment for a proposed admission, procedure or service to a specific facility and/or practitioner and for all prescribed medications or durable medical equipment; (2) the estimated out-of-pocket amount the subscriber will be responsible to pay for a proposed admission, procedure or other item or service that is a medically necessary covered benefit, based on the information available to the health plan at the time the request is made, including any facility fee, copayment, deductible, coinsurance or other out-of-pocket amount for any covered health care benefits; and (3) quality data regarding the facility and/or practitioner as specified by the Department of Health pursuant to Section 2(h), which will include, at a minimum, information on practitioner and facility performance and quality indicators, patient satisfaction, practitioner office contact, whether the practitioner is accepting new patients, credentialing, languages spoken, maintenance of certification, and network status.

(b) Estimates of Out-of-Network Costs. For a proposed admission, procedure or service provided by an out-of-network facility and/or practitioner, the estimated out-of-pocket amount the subscriber will be responsible to pay may be calculated as the difference between the maximum allowed amount and an estimate of the charge of the out-of-network facility, practitioner, pharmacy or durable medical equipment provider; provided that the health plan or third-party administrator (1) explains clearly to the subscriber that the subscriber must determine the out-of-network facility's and/or practitioner's actual charges to determine the subscriber's actual

out-of-pocket costs, and (2) discloses the [range/median] of the in-network charges for the same admission, procedure or service in the subscriber's geographic area.

(c) Binding Estimates. The subscriber shall not be required to pay more than the disclosed out-of-pocket amounts as specified in paragraphs (a) and (b) above for the covered health care benefits that were actually furnished; provided, however, that nothing in this section shall prevent health plans or third-party administrators from imposing additional cost-sharing requirements disclosed in the insured's benefits plan for unforeseen services that arise out of the proposed admission, procedure or service; and provided further, that the health plan or third-party administrator shall alert the subscriber that these are estimated costs, and that the actual amount the insured will be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

(d) All health plans and third-party administrators licensed by the State shall submit annually to the Department of Insurance detailed descriptions as to (1) the manner in which cost-sharing information is being communicated and updated to subscribers so that the Department of Insurance can ensure that this information is being transmitted to subscribers in an understandable, easy-to-navigate manner that allows the ability to compare practitioner and facility prices, quality, and care settings; (2) marketing efforts through e-mail, telephone calls, and regular mail to inform subscribers that the cost-sharing and quality information is available; (3) ongoing surveys of subscribers to determine subscriber satisfaction with the manner in which the cost-sharing and quality information is being communicated; and (4) use of the various tools that report cost of care to subscribers.

Effective Date: The effective date of the provisions of this Act shall be no later than six months after enactment.