Issue Brief: 2015 Price Transparency Initiative State Survey: Price Disclosures

OVERVIEW

State legislatures have shown a lot of interest in health care price transparency initiatives this year. At least 27 states have proposed price transparency legislation in 2015. This legislation takes the form of disclosure requirements aimed primarily at health care providers and health insurance carriers.[1] These initiatives require individual health care providers, hospitals, and insurance carriers to disclose health care prices, charges, and reimbursement rates in a variety of ways.

HEALTH CARE PROVIDERS

The majority of current price transparency initiatives are aimed at health care providers. These initiatives require providers (both individual physicians and hospitals) to disclose certain prices to patients prior to the commission of a health care service, procedure, or admission. Although all the current state initiatives have a common purpose, states seek to achieve price transparency in slightly different ways. The three primary differences among these bills center on: (1) what constitutes a service "price," (2) which services providers must disclose prices for, and (3) how providers should provide patients with service price lists.

What constitutes a health care service "price?"

State initiatives vary widely on what would comprise the service

"price" providers would need to disclose to patients. Requiring providers to apply a patient's insurance plan to the provider's flat service price before presenting patients with an estimate of a patient's actual out-of-pocket expense would be most useful to patients. Yet, only one state initiative proposes this. *See* Connecticut. Most of the remaining states would only require providers and hospitals to disclose the equivalent of a flat facility or chargemaster service price (without any application of a patient's insurance).[2] *See* Arizona(passed),[3] Indiana, Michigan, Missouri, Montana, New Jersey, New York, Oklahoma, Pennsylvania, Texas, Vermont, and Oregon (failed). These fees would have little meaning for insured patients since patients would not know how much they would end up owing after the provider applies the patient's insurance.

A few more slight variations in the definition of "price" exist. In two states, if a provider could not predict the service cost, it would be required to provide a patient with the maximum price allowed by the patient's insurer. *See* Kansas and Maine. Moreover, the failed Oregon initiative would have required providers to disclose to patients the provider-insurance company contracted prices. *See* Oregon (failed). This initiative would have been somewhat more useful to patients than a flat provider service charge, but it still would not have provided patients with an actual estimate of their cost of services. Although patients could use a coinsurance rate or copay to determine their actual or maximum out of pocket costs, legislation requiring direct statements of out of pocket costs in patient, plan, and provider specific manner would be significantly more useful.

For which services must providers disclose prices?

Another variance in provider price disclosure initiatives is the services, procedures, and admissions for which providers and

hospitals must disclose prices and charges. Bills aimed at providers differ slightly from those aimed at hospitals.

Providers

Provider-targeted initiatives take three primary forms and would require providers to give patients: the individual patient's price for her scheduled service, prices for the facility's most commonly used services, and/or prices for every service the provider offers. Most state initiatives would require providers to give patients a price estimate for services a patient has already scheduled. *See* Kansas, Maine, New Jersey, New York, and Vermont. Other initiatives would require providers to disclose the set prices for a provider's most-commonly provided services, procedures, and admissions. *See* Arizona (passed), Missouri, Colorado (failed), and Oregon (failed). The number of most-common services, for which providers would be required to report, range from the entity's top 15 to its top 100. Alternatively, a minority of provider initiatives would require providers to disclose the prices for every service the provider entity bills for. *See* Indiana and Pennsylvania.

Some of the current initiatives exempt certain providers and/or services. One bill provides an exemption for entities that have fewer than a threshold number of licensed health care providers (e.g., fewer than three). *See* Arizona (passed). Another bill would exempt providers from disclosing estimated provider charges that do not exceed $500. *See* Montana. And, almost all the price disclosure initiatives have a specific provision that exempts providers from disclosing prices for emergency services since emergencies are neither easily anticipated nor planned for.

Hospitals

In line with provider price disclosure trends, most states would

require hospitals to disclose their most commonly-billed inpatient codes, outpatient codes, and surgical and imaging procedures. *See* Arizona (passed), Missouri, Oklahoma, and Colorado (failed). Alternatively, only three states have presented legislation that would require hospitals to disclose all service charges—each of which remains active. *See* Connecticut, Michigan, and Montana. One bill exempts health care facilities with fewer than a certain number of hospital beds (e.g., fewer than 50 inpatient beds). *See* Arizona (passed). And, the same bills that would exempt providers from disclosing estimated charges that are less than $500 or emergency services, would apply in hospital settings, as well. *See* Montana.

Medicaid/Medicare Reimbursement Rates

Some states are taking price disclosure one step further by proposing legislation that would require providers and hospitals to disclose their prices alongside Medicaid and Medicare reimbursement rates for the same services. *See* Indiana, Missouri, and Oklahoma.[4] If these initiatives pass, patients would be able to access side-by-side comparisons of the non-negotiable reimbursement rate the U.S. government pays a provider for a service and the amount the provider is charging the patient for the same service. This would not only allow patients to financially plan for their health care services, it would also allow them to see the (likely lower) rate their provider accepts from the U.S. government on behalf of Medicaid and Medicare beneficiaries.

How would providers be required to disclose their service prices?

The last major variance among provider price transparency initiatives is how providers would be required to disclose their service prices to patients. Provider price disclosure

initiatives require disclosures in essentially one of four ways. First, some states would require providers to post their prices to their website. *See* Arizona (passed), Missouri, Pennsylvania, Colorado (failed), and Oregon (failed). Second, one state would require providers to post prices in their facility's common areas (waiting rooms, etc.). *See* Michigan. Third, and most popular among state initiatives, some states would require providers to present a patient with a physical list of service prices within a certain timeframe after a patient schedules a service with the provider's office (usually 3-10 business days). Some states require that providers automatically provide patients with a physical list of prices within a certain amount of time after the appointment has been scheduled. *See* Connecticut, Kansas, New Jersey, New York, Texas, and Vermont. Other states, however, would only require providers to give patients a price estimate if a patient requests it. *See* Arizona (passed), Kansas, Maine, and Oklahoma. And, finally, Arizona will require a combination of two or more of these delivery methods to ensure that patients receive provider prices. *See* Arizona (passed).

Conclusion

Presently, at least 16 states have contemplated provider and hospital price disclosures this year. One bill (Arizona) passed into law; two bills (Colorado and Oregon) failed; and another 13 bills remain active. These initiatives vary on what constitutes a "price;" on which services, procedures, and admissions providers would be required to disclose prices for; and how providers would need to deliver their prices to patients.

HEALTH INSURANCE CARRIERS

Current price disclosure initiatives aimed at health insurance carriers seek to improve price transparency via carrier

disclosure of reimbursement rates and statewide prohibitions on non-disclosure provisions in carrier-provider contracts.

Reimbursement Rate Disclosure

Some state initiatives require carriers to provide their beneficiaries with actual reimbursement rates, partial reimbursement rates, and/or patient out-of-pocket expenses for services, admissions, and procedures. *See* Maine[5] (passed), Maine,[6] Connecticut, Idaho,[7] Massachusetts, Missouri, Texas, and New Mexico (failed). Carriers would need to publish these rates and expenses on their websites and would also need to make the information available, toll-free, by phone. Three additional initiatives would also require insurance carriers to provide an estimate of payments the carrier will make for a service/supply if a beneficiary so requests. *See* Kansas, Missouri, and Texas. Although actual and partial reimbursement rates may not necessarily provide patients with the actual price or hospital charge for their health care service, procedure, or admission, the actual reimbursement rate, coupled with a provider price could provide patients with information on their out-of-pocket expenses for a partially covered service. As such, reimbursement rate disclosures have the potential to improve price transparency for patients, but because patients respond better to tools that offer more specific information (e.g., out-of-pocket expenses), this may be too burdensome—and thus not useful—for patients.

Prohibition on Price Non-Disclosure Provisions

One active Missouri initiative would prohibit providers and insurers from including price non-disclosure provisions in their contracts. *See* Missouri. Non-disclosure provisions prohibit providers from disclosing contracted provider-insurance carrier prices. Non-disclosure provisions are so powerful that they have

been the basis of successful insurance company lobbying efforts against at least one state price transparency initiative.[8]As such, statewide prohibitions on price non-disclosure provisions would be necessary to allow providers to disclose provider-carrier contracted health care prices to patients and, subsequently, to advance price transparency.

Conclusion

Although fewer initiatives are aimed at health insurance carriers than at health care providers, at least eight state bills would require carriers to provide plan enrollees with actual reimbursement rates, partial reimbursement rates, and/or patient out-of-pocket expenses. One reimbursement rate bill has already passed into law (Maine), one bill died (New Mexico), and six remain active. Furthermore, one initiative would prohibit non-disclosure provisions in provider-carrier contracts. This could be instrumental in advancing price transparency initiatives aimed at provider-health insurance carrier contract prices.

CONCLUSION

Current price transparency initiatives focus heavily on provider price, hospital charge, and carrier reimbursement rate disclosures. Although the initiatives vary widely in form, they each seek to improve health care price transparency. Three initiatives have already passed, three have failed, and many more remain active. The Source looks forward to tracking these price disclosure initiatives and updating you as they progress.

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[1]Other direct price transparency initiatives target state agencies, in the form of All Payers Claims Databases (ACPDs). This Issue Brief does not address ACPDs. We will address ACPDs

separately in an update to the Source's ACPD Issue Brief.

Moreover, other state initiatives that could have an indirect impact on price transparency do exist but fall outside of the scope of this Issue Brief. *See, e.g.*, the proposed "Pharmaceutical Price Transparency Acts" (which would require pharmaceutical companies in California, Massachusetts, New York, North Carolina, and Oregon (failed) to disclose certain information related to a drug's price—a price that would already have been disclosed); *see also*Illinois' "Medical Patient Rights Act" (which would require physicians who order—but who do not supervise or perform—certain laboratory services to disclose this information in the bill, along with the actual amount paid/to be paid to the third party laboratory); *see also* Missouri's Health Observation Status Consumer Notification Act," (which would require hospitals to provide patients with oral and written notice about a patient's inpatient/outpatient status—a status that has billing and health care price implications).

[2]Such initiatives use terms that include: "direct pay price" (Arizona); "prices" (Colorado); "chargemaster" (Indiana); "gross billed charge" (Michigan); "the amount that will be charged to a patient for each of the services as if all charges are paid in full without a public or third-party paying for any portion of the charges " (Missouri); "estimated charges" (Montana); "a reasonable estimate of the cost for the services" (New Jersey); "fee the patient will be charged for each service in the event that insurance will not cover it" (New York); "the amount to be charged for each patient . . . if all charges are paid in full without a public or private third party paying any portion of the charges" (Oklahoma); "set prices for all services" (Pennsylvania); "the price . . . that would be accepted as payment in full for the service" (Texas); and "the cost of health care services" (Vermont).

[3]The Arizona bill, which passed into law in April 2015, takes "price" one step further. The bill clarifies that a service's "direct pay price" is for the standard treatment provided for the service but adds that it *may also include*the "cost of treatment for complications or exceptional treatment." It is unclear whether "may also include" means (a) that it is at the provider's discretion to add into the price disclosure the cost of treatment should a complication occur or exceptional treatment be required or (b) that sometimes a doctor may be required to include these estimates in their patient price disclosure. It would be nearly impossible for a provider to anticipate all the possible complications for any given service, and it would be a great administrative burden to require providers to calculate all cost estimates of such complications. Since the bill is now law in Arizona, time will tell how this provision plays out in practice.

[4]Oklahoma only requires a Medicaid/Medicare reimbursement rate comparison of hospital charges; it does not require it of individual provider prices.

[5]Maine's initiative is limited, in relevant part, to "the amount of coverage provided under a health plan for out-of-network providers or non-covered health care services[.]"

[6]Maine's LD636, supra, note 3 passed. Maine LD1305 remains active and is comprised of different provisions, including a requirement that carriers provide the "average price paid in the last 12 months to network providers for proposed admissions, procedures, and services[.]"

[7]Idaho's bill would only apply to the Idaho Exchange insurers.

[8]*See* the Source's blog post, "Case Study in Price Transparency Bills: Oregon," where the Source discussed how insurance companies and health care systems leveraged non-disclosure

provisions and successfully lobbied against Oregon SB891, which would have been a comprehensive and useful price transparency law for Oregon patients.

APPENDIX A: Price Transparency Legislation By State

Passed

State	Initiative	Status
Arizona	HB2417: HEALTH SERVICE PRICE TRANSPARENCY: requires health care providers to make available, on request or online, the direct pay price for at least the twenty-five most commonly provided services, if applicable, for the health care provider. The direct pay price must be for the standard treatment provided for the service and may include the cost of treatment for complications or exceptional treatment. Health care providers who are owners or employees of a legal entity with fewer than three licensed health care providers are exempt from the requirements of this subsection. A health care provider is not required to report the direct pay prices to a government agency or department or to a government-authorized or government-created entity for review or filing. A health care facility with more than fifty inpatient beds must make available, on request or online, the direct pay price for at least the fifty most used diagnosis-related group codes, if applicable, for the facility and at least the fifty most used outpatient service codes, if applicable, for the facility. A health care facility with fifty or fewer inpatient beds must make available, on request or online, the direct pay price for at least the thirty-five most used diagnosis-related group codes, if applicable, for the facility and at least the thirty-five most used outpatient service codes if applicable, for the facility. The direct pay price is for the standard treatment provided for the service and may include the cost of treatment for complications or exceptional treatment.	Passed—Signed by the Governor on 4/10/15. Chapter 266.
Illinois	SB1630: MEDICAL PATIENT RIGHTS ACT: prohibits physicians who order, but who do not supervise or perform, an anatomic pathology service to disclose in a bill for such service: the name and address of the physician/laboratory that provided the anatomic pathology service and the actual amount paid/to be paid for each anatomic pathology service provided to the patient by the performing physician/laboratory. No patient, insurer, or other third-party payer shall be required to reimburse any licensed health care professional for charges or claims submitted in violation of this Section.	Passed—on 12/4/2014. Public Act No. 98-1127. Effective 1/1/15.
Maine	LD636: AN ACT TO PROVIDE CONSUMERS OF HEALTH CARE WITH INFORMATION REGARDING HEALTH CARE COSTS: requires carriers that offer health plans in Maine to provide enrollees and prospective enrollees with information, on a publicly accessible website, regarding: (i) each prescription drug formulary for each health plan it offers (and updates to the formulary would need to be posted within 72 hours); (ii) the requirements for utilization review, prior authorization, or step therapy for each prescription drug covered by the health plan; (iii) cost-sharing requirements for prescription drug use, including how it will affect deductibles; (iv) plan exclusions; and (v) the amount of coverage provided under a health plan for out-of-network providers or non-covered health care services, as well as any right of appeal.	Passed—On 5/19/15.

Active

State	Initiative	Status
Connecticut	SB00469: AN ACT CONCERNING DISCLOSURE OF FACILITY FEES TO PATIENTS: would require hospitals and hospital-based facilities to disclose to each patient, in writing, prior to providing services to a patient, a detailed explanation of any facility fee, including the total fee and the patient's potential out-of-pocket cost after applying any insurance coverage or other reimbursement.	Active–Referred to the Joint Committee on Public Health on 1/22/15.
Connecticut	SB00813: CONSUMER HEALTH INFORMATION WEBSITE: each health carrier would be required to develop and publish an Internet web site and institute the use of a mobile device application and toll-free telephone number to enable consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for (i) at a minimum, admissions and procedures reported to the Connecticut Health Insurance Exchange pursuant to section 2 of this act for each health care provider in the state, and (ii) prescribed drugs and durable medical equipment; (B) the estimated out-of-pocket cost that the consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, copayment, deductible, coinsurance or other expense; and (C) data or other information concerning (i) quality measures for the health care provider, as such measures are determined by the Commissioner of Public Health in accordance with subsection (g) of section 2 of this act, (ii) patient satisfaction, (iii) whether a health care provider is accepting new patients, (iv) credentials of health care providers, (v) languages spoken by health care providers, and (vi) network status of health care providers; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services. In addition, on and after October 1, 2015, no contract entered into, or renewed, between a health care provider and a health carrier could contain a provision prohibiting disclosure of negotiated pricing information, including, but not limited to, pricing information relating to out-of-pocket expenses.	Active–Tabled for the Senate Calendar on 5/22/15.
Idaho	H0151: AN ACT MAKING CERTAIN HEALTH INSURANCE EXCHANGE INFORMATION AVAILABLE: would require the health insurers on the Idaho Exchange to make available the following information: (i) prescription drugs covered by the plan, including restrictions on use or quantity; (ii) out-of-pocket expenses; (iii) network providers; (iv) coverage for out-of-network providers; (v) rights of appeal when coverage is denied; and (iv) other information deemed pertinent by the Exchange.	Active–Referred to the Committee on Health & Welfare on 2/19/15.
Indiana	HB1241: DISCLOSURE OF FACILITY CHARGES: would require hospitals, ambulatory outpatient surgical centers, and other entities that provide health care to make public on their websites: the facility's current charge master and a comparison of the facility's charges for services and the amount of reimbursement for the service or treatment under the Medicare program. Physicians would be required to make available on their websites: the physician's current charges and a comparison of the physician's charges for services and the amount of reimbursement for the service or treatment under the Medicare program.	Active–Referred to the Committee on Public Health on 1/13/15.

Kansas	SB122: FEES AND CHARGES FOR SERVICES PROVIDED AT HOSPITAL-BASED FACILITIES: would require hospitals and health systems that charge a facility fee that utilize a current procedural terminology evaluation and management (CPT E/M) code for outpatient or diagnostic testing provided at a hospital-based facility where a professional fee is also expected to be charged to provide the patient with a written notice that includes information about: the patient's potential financial liability and the fee likely to be charged. This would also need to be prominently displayed in locations that are readily accessible to and easily visible by patients. For emergency care, such written notice would need to be provided to the patient as soon as practicable after the patient is stabilized or is determined not to have an emergency medical condition before the patient leaves the hospital-based facility.	Active–Heard by the Senate on 2/6/15.
Kansas	SB172: THE PATIENT RIGHT TO SHOP ACT: would require health care entities to disclose, within two working days, the allowed amount or charge of a patient or prospective patient's admission, procedure, or service if the patient so requests. If the health care entity were not able to predict a specific code, it would still be required to disclose the maximum allowed amount.	Active–Referred to the Committee on Financial Institutions and Insurance on 2/10/15.
Kansas	SB172: THE PATIENT RIGHT TO SHOP ACT: would require health carrier to establish a toll-free phone number and a website that enables its insureds to request and obtain carrier information on the average price paid to a participating provider for a proposed admission, procedure, or service in each provider network area established by the carrier and an estimated cost. The carrier would be required to respond to an insured's request with a binding estimate for the maximum allowed amount or charge within two business days–and would include facility fees, copayments, deductibles, coinsurances, and other out-of-pocket amounts.	Active–Referred to the Committee on Financial Institutions and Insurance on 2/10/15.
Maine	LD1305: AN ACT TO ENCOURAGE HEALTH INSURANCE CONSUMERS TO COMPARISON SHOP FOR HEALTH CARE PROCEDURES AND TREATMENT: would require health care entities to disclose the allowed amount/amount to be charged at least two working days prior to a patient's receipt of admission, a procedure, or a service if a patient requests it. If the health care entity cannot predict, with certainty, the charges, it must do so to the best of its ability. Should a health care entity fail to disclose the required information, it would be prohibited from billing the patient or the patient's insurance carrier for the admission, procedure, or service. If the health care entity participates in the patient's carrier network, the entity would be required to provide sufficient information about the cost of the admission, procedure, or service via a publicly accessible website and a toll-free phone number.	Active–Carried over to the Special or Regular Session of the 127th Legislature on 6/30/15.
Maine	LD1305: PUBLICLY-ACCESSIBLE CARRIER INFORMATION: would require health carriers to a establish toll-free phone numbers and publicly accessible websites that would enable their enrollees to request and obtain information regarding the average price paid in the last 12 months to network providers for proposed admissions, procedures, and services–by geographic rating area. Health carriers would be required to provide an enrollee with a binding estimate for the maximum allowed charge within 2 business days of a request.	Active–Carried over to the Special or Regular Session of the 127th Legislature on 6/30/15.

Massachusetts	S.622: AN ACT RELATIVE TO SUPPLEMENTAL LINES OF INSURANCE: would require private health payer that small or large group health plans to make available data and other information, including: (1) average annual individual and family plan premiums for each payer's most popular plan for a representative range of group sizes, as further determined in regulations and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (2) information concerning the actuarial assumptions that underlie the premiums for each plan; (3) summaries of the plan designs for each plan; (4) information concerning the medical and administrative expenses, including medical loss ratios for each plan, using a uniform methodology, and collected under section 21 of chapter 176O; (5) information concerning the payer's current level of reserves and surpluses; (6) information on provider payment methods and levels; (7) health status adjusted total medical expenses by provider group and local practice group and zip code calculated according to a uniform methodology; (8) relative prices paid to every hospital, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider and calculated according to a uniform methodology; and (9) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology.	Active–Referred to the Joint Committee on Health Care Financing on 4/15/15.
Michigan	SB0147: AN ACT TO MAKE HOSPITAL CHARGE DESCRIPTION MASTERS PUBLICLY AVAILABLE: would require hospitals to post uniform schedule of charges represented by the hospital as its gross billed charge regardless of payer type ("charge description masters") to the hospital's website and to post a "clear and conspicuous notice" of it's Internet availability in the hospital's emergency department, admissions office, and billing office. If a hospital fails to meet these requirements, they could be fined up to $1,000 per day, per violation.	Active–Referred to the Committee on Health Policy on 2/18/15.
Missouri	HB617: HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT: would require health care providers licensed in Missouri to make public on their websites, the following information about the 25 most frequently reported health care services or procedures: (i) the amount that will be charged to a patient for each of the services as if all charges are paid in full without a public or third-party paying for any portion of the charges; (ii) the average negotiated settlement of the amount that will be charged to a patient; and (iii) the amount of Medicaid and Medicare reimbursements for health service. If a patient requests the cost of a particular service, procedure, imaging procedure, or surgery procedure, the health care provider would need to provide it within three business days. HB617 would require hospitals and ambulatory surgical centers to make publicly available the total costs for the 25 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in he hospital or outpatient settings or ambulatory surgical centers–along with CPT and HCPCS codes. If a patient requests the cost of a particular service, procedure, imaging procedure, or surgery procedure, the health care entity would need to provide it within three business days.	Active–HCS Reported Do Pass in House on 4/20/15.
Missouri	SB46: HEALTH CARE COST AND REDUCTION TRANSPARENCY ACT: would require hospitals and ambulatory surgical centers to make publicly available the total costs for the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in he hospital or outpatient settings or ambulatory surgical centers–along with CPT and HCPCS codes. If a patient requests the cost of a particular service, procedure, imaging procedure, or surgery procedure, the health care provider would need to provide it within three business days.	Active–Placed on Senate's Informal Calendar for Senate Bills for Perfection on 5/15/15.

Missouri	HB617: HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT: would require the five largest health carrier providing payment to the health care provider on behalf of insureds and state employees, to post on their websites the range of the average of the amount of payment made for each health care service or procedure. If a patient requests the cost of a particular service, procedure, imaging procedure, or surgery procedure, the health care provider would need to provide it within three business days.	Active–HCS Reported Do Pass in House on 4/20/15.
Missouri	SB46: HEALTH CARE COST AND REDUCTION TRANSPARENCY ACT: would require the five largest health carrier providing payment to the health care provider on behalf of insureds and state employees, to post on their websites the range of the average of the amount of payment made for each DRG. If a patient requests the cost of a particular service, procedure, imaging procedure, or surgery procedure, the carrier would need to provide it within three business days.	Active–Placed on Senate's Informal Calendar for Senate Bills for Perfection on 5/15/15.
Missouri	SB8: PROHIBITION ON NON-DISCLOSURE CONTRACT PROVISIONS: would prohibit the enforceability of all contract provisions entered into, amended, or renewed, between health care carriers and providers, that restrict either party from disclosing to an enrollee, patient, potential patient, or such party's parent or legal guardian, the contractual payment amount for a health care service if the payment amount is less than the health care provider's usual charge for the service and if such provision prevents the determination of the potential out-of-pocket cost for the service.	Active–SCS Voted Do Pass on 3/12/15.
Montana	HB498: AN ACT REVISING HEALTH CARE PROVIDER NETWORK DISCLOSURE LAWS: would require health care providers, outpatient centers for surgical care, clinics, and hospitals to provide patients with estimated charges for health care services or courses of treatment that exceed $500–upon patient request. The estimate would be required at the time the service is scheduled or within 10 business days of a patient's request–whichever is sooner–and must include out-of-pocket charges. This would not be required for emergency medical services provided for the treatment of an emergency medical condition.	Active–Missed Deadline for General Bill Transmittal on 2/27/15.
New Jersey	S20/A4444: THE OUT-OF-NETWORK CONSUMER PROTECTION, TRANSPARENCY, COST CONTAINMENT AND ACCOUNTABILITY ACT: would require health care facilities to, at least 30 days prior to a patient's elective, non-emergency procedure or upon scheduling it: inform a patient as to whether the provider is in or out-of-network; descriptions of the procedure; a reasonable estimate of the costs for the services; and information on all other costs related to the procedure.	Active–Reviewed by the Pension and Health Benefits Commission on 7/31/15.
New York	S00344/A00250: TRANSPARENCY IN HEALTH CARE FEES: would require health care providers to advise patients, in writing, prior to performing any health care services, the fee the patient will be charged for each service in the event that insurance will not cover it.	Active–Referred to Committee on Health on 1/7/15.
Oklahoma	HB1940: AN ACT CREATING THE OKLAHOMA HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT OF 2015: would require hospitals or ambulatory surgical centers to provide patients–upon patient request and within 3 days of the request–with information regarding the 100 most frequently reported admissions by diagnostic-related groups for inpatients, along with CPT and HCPCS codes, for hospitals that bill Medicaid, and (i) the amount to be charged to each patient for each diagnostic-related group if all charges are paid in full without a public or private third party paying any portion of the charges; and (ii) the amount of Medicaid and Medicare reimbursements for each diagnostic-related group. They would also be required to provide patients with the total costs of the 100 most common surgical procedures and 50 most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical facilities. The State Commissioner of Health may suspend or revoke the license for the operation of a hospital or ambulatory surgical center that violates the provisions of the Oklahoma Health Care Cost Reduction and Transparency Act of 2015.	Active–Referred to Rules Committee on 2/3/15.

Pennsylvania	HB774: PATIENT MEDICAL ACCESS AND AFFORDABILITY ACT: would require health care providers to establish, and post publicly on the Internet, set prices for all services, supplies, and charges. In addition, third party payors would be required to establish, and post publicly on the Internet, a fee schedule applicable to all covered individuals. Individuals would be responsible to pay the remaining balance between after the third payor has submitted the established fee for any service, supply, or charge to the health care provider. Services provided by health care providers for programs administered, regulated, or paid for by government entities would be exempt from the requirements of the Act.	Active—Referred to the Health Committee on 3/10/15.
Texas	H.B. 3102: DISCLOSURE OF PATIENT LIABILITY FOR PAYMENTS: H.B. 3102 would also require health care practitioners and facilities to, at least 3 business days prior to providing a patient with a non-emergency care, disclose the price, in writing, that would be accepted as payment in full for the service. The bill prohibits health care practitioners and facilities who do not provide proper notice from attempting to collect any payment for such services, transferring or sell a third party the right to collect any billed amount from the patient, or furnishing adverse information to a consumer reporting agency regarding the billed amount.	Active—Left pending in Insurance Committee on 4/8/15.
Texas	H.B. 3102: DISCLOSURE OF PATIENT LIABILITY FOR PAYMENTS: would require health benefit plans to, on request of a plan enrollee, provide an estimate of payments that will be made for any health care services or supply and must also specify applicable deductibles, copayments, or coinsurances—within 10 business days.	Active—Left pending in Insurance Committee on 4/8/15.
Vermont	H0197: PATIENT SERVICE PRICE DISCLOSURE: would require health care providers, except in an emergency, to disclose to a patient or other health care consumer the cost of a health care services prior to the patient or consumer incurring any charges. The patient or consumer would be required to sign a written acknowledgement of the cost disclosure. H1097 would also require hospital bills to list each service provided in language commonly understood by patients.	Active—Referred to the Committee on Health Care on 2/11/15.

Failed

State	Initiative	Status
Colorado	SB074: TRANSPARENCY IN HEALTH CARE PRICES ACT: would have required health care providers to make available to the public, in a single document, electronically or on their websites, the health care prices for (at a minimum) the 15 most common health care services they provide. In addition health care facilities would have been required to make available to the public, in a single document, electronically or on their websites the: (1) 50 most-used, diagnosis-related group codes or other codes for in-patient health care services used by the facility for billing and (2) 25 most-used outpatient CPT or health care services procedure codes used for billing.	Failed—House Committee on State, Veterans, & Military Affairs postponed the bill, indefinitely, on 3/16/15.
Oregon	SB 891: AN ACT RELATING TO THE COST OF HEALTH CARE SERVICES: would have required certain licensed health care facilities to publish their contracted charges to insurers for the top 100 most common inpatient procedures and 100 most common outpatient procedures. The information would have been published on providers' websites and directly in facilities, if requested by patient. *See* the Source's Blog post on SB891 and SB900.	Died—In committee upon adjournment.
New Mexico	SB295: SMALL GROUP RATE TRANSPARENCY: would require the superintendent of insurance to adopt and promulgate rules that require a carrier that provides a quote for a health benefit plan to a small employer disclose the history of rate changes over the preceding 5 years for the type of health benefit plan being considered.	Action postponed indefinitely on 1/22/15.

APPENDIX B: Provider Price Disclosure Legislation

What constitutes a health care service "price?"

Flat service fee with patient insurance applied	Flat service fee only	Other (allowed amount, contracted price, etc.)
CT	AZ, IN, MI, MO, MT, NJ NY, OK, OR, PA, TX, VT	KS, ME, OR

For which services must providers and hospitals disclose prices?

Only for patient-scheduled service	Most-commonly scheduled/billed services	All services
KS, ME, NJ, NY, VT	AZ, MO, CO, OK, OR	CT, MI, MT, IN, PA

How would providers be required to disclose their service prices?

Post prices on provider website	Post in provider's facility's common areas	Provide patient with a price list	More than one method
AZ, CO, MO, OR, PA	MI	AZ, CT, KS, ME, NJ, NY, OK, TX, VT	AZ