Price Transparency

The Source Blog

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cost, population health, prescribing patterns, and more.

Wisconsin confers merger review authority of healthcare consolidation to the attorney general for all nonprofit hospitals. Not only does it mandate notice to the AG, it requires approval from both the AG and relevant state agencies.

In healthcare market regulation, Wisconsin received a $2.4 million grant from CMS in 2014 to develop a state innovation plan to reduce Medicare and Medicaid costs. Wisconsin was one of the first five states to receive an approved 1332 waiver from the federal government. Recent state law mandates the Wisconsin Health Care Stability Plan (WIHSP), a publicly-funded reinsurance program, to expand access to care, reduce premium increases, keep more individuals insured, and entice insurers to offer insurance plans in the state. The program will pay insurers up to eighty percent of claims greater than $50,000 but less than $250,000. Wisconsin's 1332 State Innovation Waiver to implement WIHSP was approved by HHS through 2023.

See below for an overview of existing Wisconsin state mandates. Click on citation tab for detailed information of
Trends in Price and Quality Transparency

- All-Payer Claims Database
- Pharmaceutical Price Transparency
- All-Payer Claims Database

All Payer Claims Databases (APCD)

For more on APCD’s, check out our Legislative Topics: All Payer Claims Databases overview on Medium.
Pharmaceutical Price Transparency

Pharmaceutical Price Transparency Legislation

For more on this legislation, refer to our Issue Brief on The Source Blog and the NASHP Center for Rx Pricing.

- Key:
  - Price Transparency Legislation

Recent Action in Price and Quality Transparency

- Recent Legislation
- Recent Litigation
Recent Legislation

Surprise Billing Consumer Protection Act: A BILL to be entitled an Act to amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide for certain consumer protections against surprise billing; to provide mechanisms to resolve payment disputes between insurers and out-of-network providers regarding the provision of healthcare services; to require the department to provide for the maintenance of an all-payer health claims database; to provide for in-network cost-sharing amounts in healthcare plan contracts; to establish an arbitration process; to require the Commissioner of Insurance to contract with one or more resolution organizations; to require the promulgation of department rules; to provide for an effective date; to repeal conflicting laws; and for other purposes.

As introduced, enacts the “Modernizing Medication Utilization Act.” Beginning January 1, 2021, health plans, pharmacy benefits managers, and pharmacies must make available a patient’s specific prescription cost and benefit information in real-time for usage in a healthcare provider’s prescribing or electronic health record system at the point of prescribing and at the point
dispensing; Health plans, healthcare providers, pharmacy benefits managers, and pharmacies must partner with intermediaries, such as real-time networks, switches, and translation services, to deliver accurate, patient-specific prescription benefit and coverage, or cash pay, information to prescribing and electronic health record systems; Based on patient-specific benefit and cost information provided in real-time through a prescribing or electronic health record system, healthcare providers must provide information to the patient about the most therapeutically appropriate and lowest cost prescription medication available to the patient at the time of prescribing. This bill requires that prescription cost information displayed in a prescribing or electronic health record system at the point of prescribing include all options available to the patient, including cost options available at the patient's pharmacy of choice; any specialty pharmacy cost, as applicable; and any cash options. This bill provides that health plans and pharmacy benefit managers may not prohibit the displaying of cost, benefit, and coverage information at the point of prescribing or dispensing that reflects other choices, such as cash price, patient assistance, and support programs, and the cost available at the patient's pharmacy of choice.
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Health Care – As introduced, authorizes healthcare facilities to provide an electronic method for insureds or their representatives to acknowledge and sign the statutorily required notice that the insured agrees to receive medical services by an out-of-network provider and will receive a bill for the amount unpaid by the insured's insurer. – Amends TCA Title 33; Title 56; Title 63 and Title 68. (1) Establish an independent dispute resolution process that ensures a fair reimbursement for out-of-network services; (2) Implement a balance bill prohibition for emergency services in an out-of-network facility and for facility-based non-emergency services; and (3) Creates opportunities for transparency and notice to a patient of unexpected medical bills that arise from receiving care from out-of-network providers. Subject to certain exceptions,
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of-network facility-based physicians, and healthcare facilities. This amendment only applies to entity providing or administering an ERISA self-funded employee welfare plan if the plan voluntarily opts-in.

As introduced, extends the deadline by which the bureau of TennCare must submit an annual report to the general assembly describing the nature and purpose of any requests to utilize data from the all payer claims database submitted to the bureau or the health information committee from January 15 of each year to January 20. – Amends TCA Title 4; Title 8; Title 56 and Title 71.

As enacted, requires ambulance providers to submit an annual cost and utilization report to the bureau; authorizes the bureau, instead of the comptroller, to assess certain penalties for failure of providers to submit reports; extends the termination date of the ground ambulance provider assessment from "June 30, 2020," to "June 30, 2021." – Amends TCA Title 71, Chapter 5, Part 15.

• Recent Litigation
Law, passed in June 2015 (HB 52) by the Ohio Legislature, has been challenged by health care providers arguing that the law's requirements are too broad and would delay patient care. The law requires providers to supply patients with a "good faith" estimate of how much non-emergency, elective health care services would cost individuals after accounting for health insurance. The price transparency law was scheduled to take effect in January 2017 but has been suspended from enforcement pending the legal challenge.

The Williams County Court of Common Pleas issued a temporary injunction against the law. In February 2020, the 6th Circuit affirmed the lower court's summary judgment ruling and issued a permanent injunction, ruling that the law violated the Ohio Constitution's one-subject rule which requires that no bill may contain more than one subject, which must be clearly stated in its title. Here, the original bill was intended to regulate and fund the Bureau of Worker's Compensation, and the transparency provision was an "unnatural," unrelated addition to the bill intended to cover another subject. Additionally, the court held the transparency provision also violated the Ohio Constitution's three-reading rule, which requires every bill to
be considered by each house on three different days. The court said the entire legislative history of that bill had been about workers compensation, and when it passed both the House and Senate, it contained no reference to health care price transparency. Then on June 25, 2015, with no hearings or prior introduction, the amendment was added with the price transparency act. Attorney General David Yost's office filed an appeal March 14, 2020.

The 2019 Oklahoma law, **Patient's Right to Pharmacy Choice Act**, targets PBM conflict of interest by prohibiting higher reimbursement rates for PBM-owned pharmacies and bans PBMs from preventing pharmacies to disclose cost information to consumers. PCMA filed suit in Oklahoma district court just before the new law takes effect on November 1, 2019, arguing that the law "operates primarily to weaken competition among pharmacies by limiting the ability of PBMs to offer their cost-saving and quality assurance initiatives within the State of Oklahoma." The parties agreed to a stay in the lawsuit as the Supreme Court had granted review of the lawsuit challenging a similar Arkansas law, **PCMA v. Rutledge**.

In September 2017, just three months
after Nevada passed its insulin transparency law (SB 539) in June 2017 to increase transparency over the price of diabetes drugs, two drug lobbying groups, the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Innovation Organization (BIO), filed a lawsuit asking the U.S. District Court to declare that federal law preempts several provisions of the transparency law. SB 359 requires drug manufacturers to report a range of pricing information for a list of essential diabetes drugs compiled by the state, including pricing history and costs, price hikes above inflation, and rebates paid to pharmacy benefit managers (PBMs). Plaintiffs sued the state claiming the law is unconstitutional and deprives drug makers of their right to protect trade secrets under the Fifth Amendment. The case was voluntarily dismissed after Nevada's Department of Health and Human Services adopted a trade secret option that would allow pharmaceutical companies to keep certain drug pricing data confidential when they begin complying with the new transparency law, provided they explain why the information shouldn't be disclosed to the public. Documents related to the case can be found here.
required disclosure of generic drug pricing and sets a floor on prices that PBMs can pay to pharmacies for generic drugs. Pharmaceutical Care Management Association (PCMA), a trade association representing PBMs, brought the suit against the state in 2015.

Closely following the 8th Circuit decision in PCMA v. Gerhart handed down just two months earlier which struck down a similar Iowa law, the District Court of Arkansas was compelled to strike down the Arkansas law in March 2017. The district court found that ERISA preempted the law but Medicare Part D did not.

The 8th Circuit affirmed on appeal and held that both ERISA and Medicare Part D preempted Arkansas' drug pricing law Act 900. Arkansas filed a petition for certiorari, requesting the Supreme Court to review the case, citing split circuit court decisions in the matter of ERISA preemption of PBM laws among the 1st Circuit, 8th Circuit, and D.C. Circuit, which created "'confusion and uncertainty' about state power to regulate drug prices." Multiple states including California and New York signed on the amicus brief to the Supreme Court, urging review of the case.
In January 2020, the Supreme Court granted certiorari of the case. Oral arguments originally set for April 2020 have been postponed due to the coronavirus outbreak.

PhRMA is challenging California's drug price transparency law SB 17 alleging that the law is unconstitutional because it violates the Commerce Clause, the First Amendment, and the Due Process Clause. SB 17, which Gov. Jerry Brown signed 10/9/17, requires pharmaceutical companies to notify insurers and government health plans 60 days in advance of a price increase above a certain threshold and provide a rationale for it. After California federal court's dismissed the original suit (PhRMA v. Brown) on procedural grounds, on September 28, 2018, PhRMA amended and refiled its complaint as PhRMA v. David. Read more on The Source Blog.

In a significant victory for the pharmaceutical industry, the 4th U.S. Circuit Court of Appeals found Maryland's landmark 2017 law (HB 631), which punishes generic drug manufacturers for price gouging, unconstitutional because it violates the dormant commerce clause. The April 2018 ruling reversed the lower court's
In February 2019, the Supreme Court denied certiorari to review the 4th Circuit decision, effectively putting the nail on the coffin on the law. Read more on The Source Blog.
If you would like to report a possible data discrepancy, please email info@sourceonhealthcare.org or contact The Source here.