HJR 20: Health Care Price Transparency

Current Law and 2017 Legislation

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Background

Since 2009, Montana law has required health care providers and insurers to give certain cost information to consumers who are obtaining or considering medical treatment that would cost more than $500, if consumers ask for the information. The law requires that:

- hospitals, surgicenters, clinics, and health care providers give a good-faith estimate of charges for a health care service or course of treatment that a patient is receiving or has been recommended to receive (50-4-512, MCA); and

- health insurers provide a summary of an insured person's coverage for a specific service or course of treatment (50-4-518, MCA).

The law applies to both physical and mental health care and to any provider licensed to provide physical or mental health care in Montana, as well as to any insurer regulated under state law.

In 2017, the Montana Legislature considered four bills that would have expanded on the current law. All four bills failed to make it through the legislative process. However, lawmakers approved House Joint Resolution 20 for a study of transparency in health care pricing. The study ranked first among the 20 approved study resolutions in a post-session poll indicating legislative interest in the various studies.

This briefing paper summarizes the 2017 transparency bills and provides a comparison of the key elements of the two bills that almost made it to the finish line during the session.

Summary of 2017 Legislation

The following transparency bills considered in 2017 tried to make it easier for consumers to understand the costs they would incur for medical services and avoid unexpected costs. Various versions of the bills also included incentives for consumers to shop around for medical care, as a way to encourage competition and reduce overall health care costs.

- **House Bill 123**: Sponsored by Rep. Amanda Curtis at the request of then-State Auditor Monica Lindeen, HB 123 was designed to reduce the chances that someone would receive a "surprise" medical bill containing unexpected charges. The bill originally would have changed the current cost disclosure laws to require health care providers to indicate the health insurance networks in which they participate; indicate whether services from other health care providers may be needed to complete care; indicate whether an estimate of the charges for other services must be obtained separately; and allow patients to opt out of receiving services from a nonparticipating health care provider if doing so would not affect the course of treatment. It also would have required insurers to provide information about out-of-pocket costs from nonparticipating health

care providers; inform patients of their right to opt out of receiving services from a nonparticipating provider; and provide a list of participating providers located within a reasonable distance.

The bill was amended throughout the process and died when a conference committee's work on the bill was not accepted by the Senate. The final version of the bill included many of the provisions contained in Senate Bill 96.

- **House Bill 400**: Sponsored by Rep. Greg Hertz, this bill would have required providers to disclose more information about the costs of the health care services they offer. The bill called for health care providers and facilities to make their chargemaster or another list of billed charges available for each health care service they offer. Providers also were to indicate the network status of the provider for the patient' s health plan, if known, and say whether the services of other providers may be necessary. A provider or facility that failed to disclose the information would have been unable to collect on any amounts owed by the patient or take any action that might affect the patient's credit rating.

  The bill was tabled in the Senate Public Health, Welfare, and Safety Committee.

- **Senate Bill 96**: Sponsored by Sen. Cary Smith, SB 96 expanded on the disclosure requirements for both health care providers and insurers by adding provisions related to out-of-pocket costs. It also required insurers to establish websites where insured individuals could get information on the payments that the insurers would make to in-network providers for certain services that were considered "shoppable." Insurers were to offer cash or other incentives to people who chose to receive shoppable services from providers who charged less than the average price paid by the insurer for the service. Consumers could have filed complaints with the Department of Justice if they believed a health care provider had failed to provide a good-faith estimate; providers could not have tried to collect any disputed amounts until the complaint was resolved.

  The bill was tabled in the House Human Services Committee, but key elements were amended into HB 123.

- **Senate Bill 362**: Sponsored by Sen. Ed Buttrey, this bill expanded on the disclosure requirements for health care providers, including network status and whether services may be needed from other providers. A provider who failed to disclose the information could have faced financial penalties. The bill also required insurers to create transparency tools that would allow insured individuals to find out their out-of-pocket costs and potential costs of out-of-network services, along with quality ratings or measures for providers offering the health care service. The bill originally required insurers to offer a cash or other type of incentive to people who chose lower-cost health services of acceptable quality. However, that requirement was removed from the final version of the bill.

  The bill passed the Legislature but was vetoed by the governor.

KEY ELEMENTS OF HB 123 AND SB 362

Of the four transparency bills, House Bill 123 and Senate Bill 362 made it the farthest through the legislative process. HB 123 failed late in the process when a conference committee report was not accepted. SB 362 passed the Legislature but was vetoed by the governor.

The tables below show how the two bills were similar to and differed from each other in terms of their requirements for health care provider and insurer disclosure, online transparency tools, and incentive programs for shopping for health care services.

Provider Disclosure

Provision	HB 123	SB 362
Dollar Threshold for Disclosure	• $500	• $250
Timeline for Disclosure	• Within 5 business days of request	• After receiving all necessary information, within: ▸ 5 business days if provider has more than 5 FTE ▸ 10 business days if provider has 5 or fewer FTE
Information Required to Be Disclosed	• Network status of provider, if known • Whether other services may be required • Cost of those services must be obtained separately • Patients must be informed they can opt out of services	• Network status of provider, if known • Whether other services may be needed, if known • Cost of those services must be obtained separately • Uninsured consumers must be told about: ▸ any financial assistance the provider can offer ▸ any available websites that have cost info
Health Care Providers Included	• Individuals: Any licensed health care provider • Facilities: Hospitals, surgicenters, and clinics	• Individuals: Physicians or any licensed health care provider working for a covered facility • Facilities: Hospitals, surgicenters, and clinics
Exemptions	• Emergency treatment	• Emergency treatment
Definitions that Differed	• Billed charge	• Estimate of total charges
Penalty for Failure to Comply	• Consumer protection complaint filed with Department of Justice	• Complaint filed with Department of Public Health and Human Services • Maximum penalty of $500 per occurrence

Insurer Disclosure

Provision	HB 123	SB 362
Dollar Threshold for Disclosure	• $500	• $250
Timeline for Disclosure	• Within 5 business days of request	• Not specified
Allow Use of Transparency Tool to Provide Information?	• Yes, if it calculates deductibles and cost-sharing	• Yes, if it calculates deductibles and cost-sharing
Basis for Estimate	• Procedure codes from health care providers	• Procedure codes from health care providers
Other Requirements	• Advise patients of their rights in outline of coverage • Provide contact information for participating providers who could offer the service	• None
Health Care Providers Involved	• Individuals: Any licensed health care provider • Facilities: Hospitals, surgicenters, and clinics	• Individuals: Any licensed health care provider* • Facilities: Hospitals, surgicenters, and clinics
Exemptions	• Emergency services	• Not specified
Definitions that Differed	• Billed charge	• Estimate of total charges

* Only physicians or health care providers working for an identified facility would have to provide an estimate of charges if services had not yet been provided.

Insurer Transparency Tool/Incentive Programs

Provision	HB 123	SB 362
Information to Be Available	• Payments to be made to in-network providers • Insured's out-of-pocket costs for in-network providers • Provider quality measures based on CMS standards • Amount and type of incentive available for shopping	• Comprehensive estimate of total charges • Costs to be paid by insurance plan • Consumer's out-of-pocket costs • Provider quality measures, if available
Provider Information Included in Transparency Tool	• Individuals: Any licensed health care provider • Facilities: Hospitals, surgicenters, and clinics	• Individuals: Physicians, pharmacists, nurses, chiropractors, and naturopathic physicians • Facilities: Hospitals, surgicenters, and clinics
Insurers Required to Offer Transparency Tool	• All state-regulated insurers except public employee plans at state and local levels	• All state-regulated insurers and public employee plans except health maintenance organizations
Health Care Services Included in Transparency Tool	• Insurance commissioner to identify services	• Insurers to identify services
Definitions that Differed	• Billed charges	• Estimate of total charges • Out-of-pocket expense
Incentive Program	• Insured person shares in savings from shopping for services	• No incentive program