TESTIMONY

The Importance of Price Transparency from the Employer and Consumer Perspective

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Statement of:

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Chairman Baucus, Ranking Member Hatch, distinguished Committee members. I am Suzanne Delbanco, executive director of Catalyst for Payment Reform (CPR). Thanks for the opportunity to be here with you to discuss the importance of transparency in health care pricing as a means to achieving a higher quality and more affordable health care system.

Background

Catalyst for Payment Reform (CPR) is an independent, non-profit organization working on behalf of large employers and public health care purchasers to catalyze improvements in how we pay for health services and to promote higher-value care in the U.S. Currently, CPR has 30 members, mostly large private employers, such as 3M, Dow Chemical Company and Safeway, as well as eight state agencies such CalPERS—California's Public Employee Retiree System-- and the Medicaid agencies from Arizona, Ohio, South Carolina, and Tennessee.

CPR's long term goal is to spur changes in how we pay for health care so that our members and the rest of the nation can get better value for every health care dollar. By value, we mean the best combination of quality and costs. But there are other building blocks that must also be in place to drive our health care system to produce better and more affordable care. CPR designated price transparency as one of its special initiatives because we cannot imagine a high-value health care system without it.

What Has Led to the Call for Price Transparency Today?

Employers and other health care purchasers, as well as individual consumers, continue to face rising health care expenditures. Employers' health care costs continue to rise -- a March 2013 report indicates average employer costs are expected to increase 5.1% in 2013.[i] As a result of these growing costs, and in an effort to stem them, employers are asking those for whom they provide health care

benefits to take on a greater share of the cost. Whereas consumers have not been a significant force in the past, employers are now designing and implementing employee benefits, such as high-deductible, consumer-driven health plans, to motivate consumers to seek more efficient, higher-quality care. In fact, deductibles more than doubled between 2003 and 2011,[ii] and 34% of employer-sponsored plans now have deductibles of $1,000 or more.[iii] Consumer-directed health plans are now the fastest growing type of health plan, with 19% of covered workers currently enrolled in them.[iv] This is expected to grow in response to the requirements of the Affordable Care Act.

Total out-of-pocket spending by consumers is now at an estimated $312 billion annually.[v] But while many consumers now have a more vested interest in expending health care resources carefully due to new benefit designs, health care costs are also becoming unaffordable for a growing number of Americans. The rate of increase of average family premiums has exceeded the consumer price index and is chiefly responsible for the stagnation of family incomes.[vi] Premiums now account for 20% or more of the average American family's income.[vii]

Purchasers believe that pressure from consumers for higher-quality, more affordable care, is a powerful, underused lever. Once consumers are positioned to shop actively for medical services due to increased financial responsibility, it is important to make information about those medical services transparent to facilitate their decision-making. For a consumer strategy to succeed, it is critical to expose the variation in prices for services – the prices for standardized services such as colonoscopy can vary as much as 1000%.[viii] It is also critical to provide consumers with meaningful quality information to help them identify high-value providers, especially because price is rarely indicative of quality.

There is much greater awareness of unwarranted payment variation now than in the past. In 2010, CPR commissioned Paul Ginsburg of the Center for Studying Health System Change to examine variation in commercial payment amounts across and within eight markets. Three large private health insurers

provided data which illustrated, for example, that in San Francisco the average inpatient hospital payment rates were 210% of Medicare whereas in Los Angeles, the average inpatient stay at the 25th percentile cost 84% of Medicare, at the 75th percentile cost 184% of Medicare, and the highest paid hospital received 418% of Medicare. Ginsburg concluded that payment variation seems to be tied to provider market power, which is likely to create even greater disparities as consolidation continues and put more providers in a position of being able to refuse requests for price transparency.

What is Price Transparency?

CPR uses the U.S. Government Accountability Office's (GAO) definition of price transparency, which is "the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties." GAO defines price as "an estimate of a consumer's complete health care cost on a health care service or set of services that (1) reflects negotiated discounts; (2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician and lab fees; and, (3) identifies the consumer's out-of-pocket costs (such as co-pays, co-insurance and deductibles)."[ix]

How Could Price Transparency Help Employers and Consumers?

Transparency on health care prices increases the likelihood that consumers will choose health care providers that deliver effective and cost-efficient care.[x] Price transparency can also be an important tool for health care providers. Recent studies suggest that price transparency can help providers evaluate and identify the most appropriate and affordable care for their patients.[xi] Furthermore, employers and health plans cannot implement some of the more promising benefit and network designs without it.

Reference and value pricing are examples of such approaches. Reference pricing establishes a standard price for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount. Value pricing is when quality is also taken into consideration in addition to the standard price.

Two of CPR's members, CalPERS, and Safeway, Inc. have led the way in experimenting with using reference pricing to signal to providers that their unwarranted price variation is no longer acceptable and to engage consumers in making more value-oriented selections of providers. Price transparency is at the core of these programs, enabling consumers to minimize their financial exposure. For example, CalPERS set a reference price for hip or knee replacement at $30,000. CalPERS enrollees are responsible for coinsurance of 10% of the allowed charge, which is capped at $30,000. If a patient receives care from a facility that charges more, that patient would pay 10% coinsurance on $30,000 and the full difference between the allowed charge and the $30,000 reference price. CalPERS has said that it saved $16 million in the first year of the program.[xii]

What Efforts Exist to Advance Price Transparency Today?

The main activity in the private sector comes in the form of transparency tools that have been developed by health plans and independent commercial vendors. There is solid competition in this space and these tools vary in functionality and availability, though they have been rapidly improving in recent years and even months.

While the health care industry could, on a voluntary basis, provide highly-effective price transparency to health care consumers, there may be instances in which government must step in to ensure that citizens have access to sufficient price information to support the selection of high-value providers. The federal government has made some strides in the area of transparency in health care. On the price front, the

Center for Medicare and Medicaid Services (CMS) provides an online tool that provides beneficiaries with expected out-of-pocket drug costs, and just recently released hospital charge information. On the quality front, CMS also operates Hospital Compare, Physician Compare and Nursing Home Compare which all post provider performance on a variety of quality metrics.

At the state level, 34 states currently require reporting of hospital charges or reimbursement rates. Some states operate consumer-facing transparency tools such as "New Hampshire Health Cost" and in Massachusetts, "My Health Options." In the Report Card on State Price Transparency Laws, CPR worked with the Health Care Incentives Improvement Institute to examine existing states laws on price transparency to determine whether states were stepping in to provide consumers with price information. Forty-three states have laws that address price transparency in health care in some manner. The Report Card graded state laws on four dimensions: 1) on what breadth of services they require price information be available; 2) on what breadth of providers they require price information be available; 3) whether the law required provider charge information versus the actual negotiated payment amount; and, 4) how accessible the price information was to consumers. Just two states, New Hampshire and Massachusetts, earned 'A' grades according to criteria in these four dimensions, while 29 received an F due to the absence of any laws or laws that met few of the criteria.

What are the Challenges to Achieving Effective Price Transparency?

In the commercial sector, it is very difficult for health plans, employers or other vendors to produce transparency on prices for all health care providers. There are some health care providers, particularly those with market power, who put into their contracts with health plans a prohibition on revealing to health care purchasers or consumers any information about payment amounts. While health plans are working independently and through legislation to phase out such contract provisions, and they are relatively rare, in some markets where dominant providers succeed in achieving these terms, there can

be gaping holes in the information consumers need to make informed decisions about where to seek care. As a result, while price transparency could be an effective element of introducing greater competition and innovation in the health care delivery system, market power may allow those providers with higher-than competitive prices to keep their high-prices obscured.

Another barrier to employers and consumers having the most effective price transparency is the position of some health plans that information contained in health insurance reimbursement claims data, particularly the payment amounts, is proprietary. They take this position even in the case of customers for whom they provide administrative services only and do not take on the insurance risk (e.g. a self-insured employer). As a result, some health plans will not permit self-insured customers to give their own claims data to a third-party vendor, such as Castlight Health, to populate a consumer price transparency tool.

Making transparency in health care work for consumers can be challenging. Without both price and quality transparency, consumers may get the wrong message – consumers could mistakenly correlate higher prices with higher quality, which is often not true in health care.[xiii] In addition, our current reliance on fee-for-service payment, with individual codes for every test, procedure and visit, may make it hard for lay consumers to estimate their total costs for an entire episode of care since they make not know what the components of their care will be.

Price transparency alone is unlikely to change consumer behavior. Pairing it with some sort of incentive to use it and to act on it is more likely to engage consumers. New benefit designs can make price and quality information meaningful, such as the reference pricing example above.

Furthermore, it is unknown how providers will react to greater price transparency, particularly if transparency is implemented in such as way as to enable them to gain access to each other's negotiated

payment amounts. It is possible that less expensive providers may try to raise their rates to those of their higher-priced competitors. It is also possible that providers with prices higher than the average would bring their prices down out of fear of losing patient volume. This is an area that needs further research.

How is CPR Working to Meet the Needs of Employers, other Health Care Purchasers, and Consumers?

In our work to support employers and others who purchase health care for consumers, CPR has created a variety of tools to help them advance price transparency in health care.

Most employers and other health care purchasers rely on health plans to act as their agents in the health care marketplace, administering benefits and contracting with health care providers on their behalf. As a result, CPR has developed a series of tools as well as venues in which purchasers can push health plans to meet their need for price transparency.

In order to alert health plans about the priority purchasers place on price and quality transparency, we have created standard questions that purchasers can pose to them when they are determining which health plans with whom they would like to contract. We have also created model health plan contract language purchasers can use as a starting point for contract negotiations with the plans. This model language outlines the purchaser's expectations of the contracted health plan regarding price and quality transparency. We support both of these sourcing and contracting approaches with CPR-moderated user groups that occur quarterly between each of the four largest national health plans and their employer-purchaser customers. At each meeting, we ask the health plans to report their progress on their own price transparency tools, whether they meet CPR's specifications for these tools (more detail below), whether they allow self-insured customers to give their own claims data, including the payment component, to a third-party vendor for analysis or for use in a transparency tool, and what percent of

their professional claims and hospital claims run through health care provider contracts that limit sharing price and quality information with consumers.

In response to the various frustrations many employers and other health care purchasers have experienced in seeking the cooperation of health plans and health care providers to make health care prices transparent, CPR issued its Statement on Price Transparency to request that health plans and health care providers remove these barriers by January 1, 2014. This statement was also endorsed by many other business groups as well as the AFL-CIO and AARP.

In its first National Scorecard on Payment Reform, released on March 26, 2013 and designed to track the nation's progress on payment and other related reforms, CPR found that 98% of health plans say they have cost calculator tools of some kind. However, they also reported that only 2% of patient members ever use them. We will track this finding over time as we release subsequent annual Scorecards.

While there is a proliferation of consumer transparency tools, not all of them are easy to use or provide meaningful information. After reviewing the leading consumer transparency tools about 18 months ago, when CPR found many helpful features spread across the various tools but not all contained in any one tool, CPR decided to create Comprehensive Specifications for the Evaluation of Consumer Transparency Tools as of way of pointing to the features we think tools must contain to be effective. Most tools, whether designed and operated by health plans or independent vendors are getting better rapidly. However, one of the biggest shortcomings is the separation of price and quality information, which can make it very difficult for the consumer-user to identify which provider or procedure options offer the best overall value.

How Could the Federal Government Advance Price Transparency?

The various stakeholders in the health care industry that are privy to price information could work together to provide effective price transparency. But since a voluntary effort is unlikely to lead to complete transparency, there is a role for government. The federal government could facilitate price transparency in a variety of ways.

First, building on its recent release of hospital charge data, it could share charge, payment, and quality information for a much broader range of providers and services.

Second, in the federal government's efforts to provide transparency tools for consumers, such as www.hospitalcompare.gov, it could work to incorporate the features designated as most important in CPR's Comprehensive Specifications for the Evaluation of Consumer Transparency Tools. The federal government also has a unique role to play in meeting the price transparency needs of those receiving health benefits from the federal government as well as the uninsured.

Third, the federal government could, through the federally-facilitated exchanges, insist on price transparency from qualified health plans. CPR's model health plan contract language includes price transparency requirements that could be used by exchanges in their contracting with these plans.

Lastly, in order to help employers and other self-insured customers of health plans meet their fiduciary obligations in the delivery of health benefits, the federal government could ensure they have access to their own claims data, including the payment component, for use in consumer transparency tools, including those operated by third-party vendors.

There is also a role for state government to play. States can implement laws that require health care prices (not just charges) in the commercial sector for a broad range of health care services and providers

to be easily accessible to consumers. The State Report Card on Price Transparency Laws outlines the criteria that it takes to be an 'A' state in this regard. States can also create All Payer Claims Databases designed to produce robust quality and price information for use by consumers.

Conclusion

Large employers and other health care purchasers cannot envision a high-value health care system in which there is not meaningful and usable price and quality transparency. Catalyst for Payment Reform commends the Senate Finance Committee for delving into this issue. CPR will continue to work to ensure that employers and consumers can be armed with the information they need to help evolve our health care system to one in which we understand and feel confident about the value we are getting for each health care dollar we spend.

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APPENDIX

CATALYST FOR PAYMENT REFORM

Price Transparency

An Essential Building Block for a High-Value, Sustainable Health Care System

Action Brief

INTRODUCTION

As health care costs continue to rise, purchasers remain focused on strategies that can help to bring costs under control. These pressures have facilitated a movement by many purchasers to engage consumers – their employees and their dependents – more fully in their health care decisions, including taking on a greater share of their health care costs. In their efforts to manage costs, health care purchasers, including large employers and states, recognize consumers need information on both health care price (particularly a consumer's expected out-of-pocket contribution) and quality (especially outcomes measures and other measures of safety, effectiveness, timeliness, efficiency, and equity),[1] along with the right incentives to seek higher-value care. In recent years, information about quality has become more transparent; however, meaningful price information is still difficult to obtain.[2] Purchasers, plans, and providers need to do more to advance price transparency and to marry price and quality data together to help consumers assess their treatment options.

What is price transparency? Why should purchasers push to make price and quality information public? What are some of the existing tools and strategies in the current marketplace and their limitations? This Action Brief examines these questions and provides purchasers with concrete ways they can foster transparency, which in turn can help catalyze much needed reform in our health care system.

WHAT IS PRICE TRANSPARENCY?

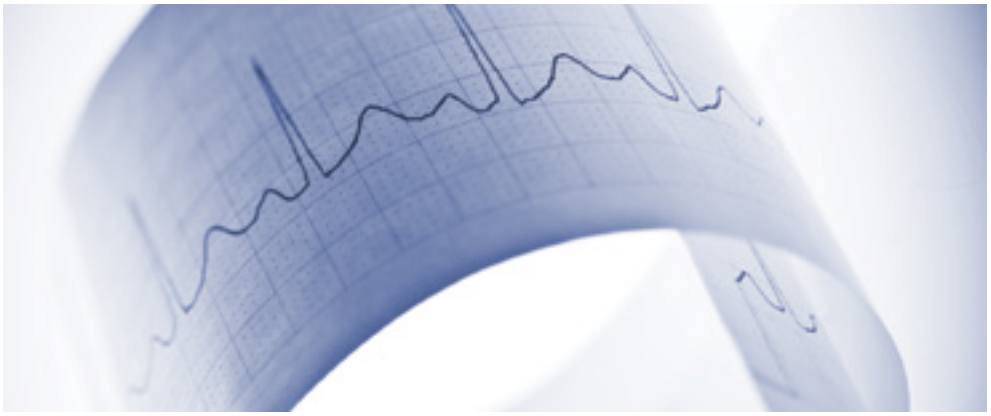
Depending on who you talk to in health care, "price transparency" can have many different definitions. For the purposes of this Action Brief, Catalyst for Payment Reform (CPR) defines price transparency as "the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties."[3]

Price is defined as "an estimate of a consumer's complete health care cost on a health care service or set of services that 1) reflects any negotiated discounts; 2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician and lab fees; and, 3) identifies the consumer's out-of-pocket costs (such as co-pays, co-insurance and deductibles)."[4]

The price a consumer pays for a particular service depends on a number of variables

PRICE EXAMPLE: An insurer has negotiated a rate of $1,000 with a particular in-network provider for a chest MRI, and therefore, the cost is $1,000. A consumer has $200 remaining to meet his/her deductible and the coinsurance is $160; the individual is responsible for $360 and the insurer pays $640. In this case the consumer's "price" for the MRI is $360. Price transparency exists when, for example, prior to seeking care, a consumer knows his price will be $360 for that particular provider and can compare the price for chest MRIs with other providers.

It is also important for consumers to understand the total payment for the service, including what the plan (or purchaser) pays and the remaining price they owe for that service. This broader context is important as we inform consumers about the total cost and price of specific health care services as they make decisions and seek care in the health care system.



Some of the most promising payment reform approaches such as reference and value pricing cannot be implemented effectively without price transparency.

including whether that consumer is insured or uninsured and whether the provider who performs the service is "in-network" or "out-of-network." For uninsured consumers, the price for a service is always the same as the total payment a provider receives. For insured consumers who have not yet met their deductible or are visiting an out-of-network provider when their health plan has no out-of-network benefit, the price of care is also the same as the total payment to the provider. However, for insured consumers visiting an in-network provider, the price of care will often represent only part of the payment for that care; the insurance plan will pay the rest. Regardless of the arrangement, the "price" as understood herein is the amount of payment for which the consumer is responsible. Despite one's insurance status, however, it is important to note that maximizing the consumer benefits of price transparency will require attention to medical literacy issues, including the fact that it can be very challenging for most health care consumers to understand medical terms as well as how health care payment works, including their own insurance benefits and billing.

WHY SHOULD PURCHASERS SUPPORT TRANSPARENCY?

Purchasers and consumers need transparency for three primary reasons: (1) to help purchasers contain health care costs; (2) to inform consumers' health care decisions as they assume greater financial responsibility; and, (3) to reduce unknown and unwarranted price variation in the system.

PURCHASER COST SAVINGS Based on a 2012 report, health care costs rose only 5.4% in 2011 because of benefit plan redesign and increases in employee contributions. Without changes to plan design and increases in employee contributions, "average cost trends would have been 8% in 2011 and anticipated to be only slightly lower (7.4%) next year."[5] Another recent report indicates that large employers expect health care costs to rise by 7% in 2013.[6] While this stabilization in trend may be a testament to the impact of current efforts, health care costs are still growing at about twice the rate of the general Consumer Price Index; in fact, health care cost trends have outpaced wage growth for more than a decade.[7]

To address these trends further, many purchasers are implementing a variety of cost containment strategies, including care management of high-cost patients, reference pricing, centers of excellence for high-cost, complex services, and other strategies including wellness incentives and more extensive coverage of preventive care. Purchasers aiming to manage health care costs by implementing these payment reforms and benefit design changes will find price transparency essential to their strategies. Some of the most promising approaches such as reference and value pricing cannot be implemented effectively without price transparency.[8]

SUPPORTING CONSUMERS AS THEY ASSUME GREATER FINANCIAL RESPONSIBILITY As health care costs continue to rise, most purchasers are asking their consumers to take on a greater share of their costs, including both health insurance premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, consumers pay 47% more for coverage than in 2005 while wages have only increased by 18%.[9] Furthermore, 34% of employer-sponsored plans have a deductible of $1,000 or more for single coverage, more than three times the average in 2006. Enrollment in consumer-driven health plans (CDHP), such as health savings accounts (HSAs), has risen to 19% of all employer-sponsored plans, making them the second most popular plan type after traditional PPOs.[10] According to an American Association of Preferred Provider Organizations (AAPPO)-commissioned analysis of the Mercer National Survey of Employer-Sponsored Health Plans, 61% of *large* employers and 48% of *all* employers expect to offer CDHPs five years from now. These trends, coupled with overall increases in health care expenditures, mean consumers now spend $312 billion out-of-pocket annually.[11] Even with the Patient Protection and Affordable Care Act's (PPACA) pending guidelines on the maximum deductible and out-of-pocket expenditures for family coverage at $4,000 and $11,900 respectively, these trends will still continue.[12]

Despite taking on a greater share of their health care costs, consumers cannot be prudent health care shoppers without information on quality and price. Consumers research quality and prices regularly for a variety of goods and services, from cars and washing machines to mechanics and restaurants. Research[13] – and common sense – indicates they need and want easy-to-understand, quality *and* price information about their care. Consumers seeking non-urgent care would benefit the most from access to price and quality information because they have time to examine data and make decisions about predictable services, unlike in emergency situations.[14] And consumers have proven that when they have price and quality information, they in fact make strong decisions based on value. Research shows that when they have access to well-designed reports on price and quality, 80% of consumers will select the highest-value health care provider.[15]

REDUCING UNWARRANTED VARIATION Several health care researchers have examined the topic of price variation and found that significant price variation exists for hospitals and physician services across markets and even within markets. Without transparency, those who use and pay for care may be unaware of the range in potential costs and what little relationship price has to quality. In extreme cases, some hospitals command almost 500% of what Medicare pays for hospital inpatient services, and more than 700% of what Medicare pays for hospital outpatient care.[16] Variation in payment to providers can be as much as ten-to-one for services like colonoscopy and arthroscopy

Some hospitals command almost 500% of what Medicare pays for hospital inpatient services, and more than 700% of what Medicare pays for hospital outpatient care.

The implementation of a transparency tool with consumer adoption and behavior change can provide cost reductions for purchasers. For example, a purchaser with a median health care cost trend and 20,000 consumers could expect to save $6.7 million of health care spending over three years. This projection is based on consumer adoption rates of 10% in the first year to 50% by the third year.[17] Coupling transparency with related benefit strategies has proven even more effective. CalPERS instituted limited price transparency and reference pricing with high-quality medical centers for hip and knee replacements and estimated $16 million in savings in 2010.[18]

Without price transparency, it is difficult for anyone to understand the extent of price variation, its causes, or the ability of purchasers to address the problem.

in a single geographic area.[19] Studies on price variation suggest that it is largely due to provider market power resulting from "must have" status in a network, unique service offerings, and/or size.[20] The recent trend in provider consolidation has given some provider systems even greater market power relative to their peers.[21] Recent reports from the Health Care Cost Institute show a 4.6 percent increase in private spending over 2010-2011, due almost wholly to higher prices, not utilization or the intensity of services.[19] Without price transparency, it is difficult for anyone to understand the extent of price variation, its causes, or the ability of purchasers to address the problem.

WHAT ARE SOME OF THE EXISTING EFFORTS ON PRICE TRANSPARENCY?

Health plans, with their extensive data on claims, contractual reimbursement, credentialing and quality information, may be best positioned to disclose price and quality information today. Some health plans are trying to offer members access to shopping and transparency tools; however, many of these tools are currently limited in their scope and in the specificity of provider prices. This is partly due to pressure from the providers with whom they negotiate, operational challenges with respect to the data, and limitations of existing consumer portals. The additional presence in the market of other independent vendors developing similar tools is also likely spurring the creation of better tools at a faster rate. States and the federal government may also take steps to move price transparency forward in a comprehensive and meaningful way.

KEY ELEMENTS OF COMPREHENSIVE TRANSPARENCY TOOLS FOR CONSUMERS

CPR has developed a comprehensive set of specifications to help purchasers evaluate existing health care transparency tools. Such tools must provide access to broad information about providers and the services they offer. The best tools will present information intuitively so consumers can easily use it to decide where to go for care. Ideally, information would be on a single integrated platform of web and mobile applications and paired with trained support personnel such as nurses, coaches, or other customer representatives.

CPR developed these specifications after reviewing the capabilities of existing tools and with consideration of criteria developed by other organizations. The specifications fall into five categories:

1. **Scope** – the comprehensiveness of provider, including in-network and out-of-network providers, and service information, including price, quality, and consumer ratings.
2. **Utility** – the capability of the tool to facilitate consumer decision making through features that permit comparisons of health care providers' prices, quality, and care settings.
3. **Accuracy** – the extent to which consumers can rely on the provider, service, and benefit information.
4. **Consumer Experience** – the user-friendly nature of the tool, including the availability of mobile applications and easy-to-find, easy-to-understand information.
5. **Data Exchange, Reporting and Evaluation** – the extent to which claims data are exchanged with purchasers according to all privacy laws, the ability of purchasers to use the data with third-party vendors, regular reporting to the purchaser, ongoing improvement of the tool, and the ability of users to rate the tool.

HEALTH PLAN TOOLS AND PURCHASER DATA National health plans are heeding the call from purchasers to share price and quality information with consumers and are developing transparency tools for their patient members to help them access and understand these data. Some plans have had tools for several years, while others just months. Even in the most sophisticated tools, precise price transparency is still relatively rare. CPR's review of the current cost calculators or estimators offered by some of the largest health plans[23] found they provide varying levels of price transparency for select services. The Pacific Business Group on Health also recently performed a "secret shopper" study of the tools developed by major health plans.[24] The results demonstrate wide variation in their functionality and cost comparison capabilities. Examples of differences include variation in the number of services for which price information is available and the ability to compare prices across care settings. In response, some purchasers are turning to third-party vendors – separate from their health plans – to create tools for their consumers. However, this requires health plans to release purchasers' data to a third-party vendor, which many health plans have not yet agreed to do.

OTHER VENDORS' ACTIVITIES Like health plans' tools, other vendors' tools vary in functionality and in the scope of information they offer. Many tools focus solely on price, or estimates of price. Others exclusively present quality and patient-submitted reviews. Some tools even alert consumers about opportunities to lower their out-of-pocket costs and can be customized to individual benefit designs. Only a few comprehensively provide information on quality, price, patient experience, network providers, and benefit design.

These transparency tools also have their limitations. Other vendors typically do not have access to real-time data for their tools as health plans do. They may also have to obtain medical, pharmaceutical, behavioral and other clinical claims data from multiple sources to populate the tool. Despite these limitations, other vendors' tools play a valuable role, particularly when health plan tools do not meet the needs of purchasers and consumers. Their presence in the market enhances competition and spurs innovation to make more robust, user-friendly tools available.

STATE ACTIVITY Currently, 34 states require reporting of hospital charges or reimbursement rates[25] and more than 30 states are pursuing legislation to enhance price transparency in health care.[26] The structure and requirements of the laws and pending legislation vary widely by state and some only include pilot programs and pre-implementation steps. While most states have some disclosure requirements in place, these statutes generally do not cover the actual prices specific providers charge for performing specific treatments.[27]

Currently, 34 states require reporting of hospital charges or reimbursement rates and more than 30 states are pursuing legislation to enhance price transparency in health care.

When well-designed databases collect the right information, they can transform data into valuable price and quality information.

In recent years, several states, such as Massachusetts, Maryland, and Utah, have also established databases that collect health insurance claims from health care payers into statewide repositories. Known as "all-payer claims databases" (APCD) or "all-payer, all-claims databases," they are designed to inform policymakers and other stakeholders about various state-based cost containment and quality improvement efforts. According to the APCD Council, nine states operate mandatory APCDs,[28] three states are currently implementing mandatory APCDs,[29] and two states have voluntary APCDs.[30, 31] State laws can direct an APCD on what information it collects and reports. When well-designed databases collect the right information, they can transform data into valuable price and quality information.

California has a new voluntary, multi-payer claims database managed by the Pacific Business Group on Health. The new platform, a nonprofit entity called the California Healthcare Performance Information System (CHPI), will pool claims and other data from California health plans and CMS. CHPI is applying to be deemed a Medicare Qualified Entity so that it can include Medicare claims data (on California's Medicare beneficiaries). CHPI will produce physician, group and hospital performance ratings using quality, efficiency, and appropriateness measures.

States have taken additional steps to ensure that claims information is not restricted under contractual stipulations such as "gag clauses." California recently signed into law SB1196 which states, "No health insurance contract in existence or issued, amended, or renewed on or after January 1, 2013, between a health insurer and a provider or a supplier shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to a policyholder or insured of the insurer or beneficiaries of any self-insured health coverage arrangement administered by the insurer."[32] In practice, the law will allow plans to share data with Medicare Qualified Entities.

Some states have developed their own price transparency tools for consumers. Both New Hampshire and Maine have posted health care costs on state-sponsored websites called New Hampshire Health Cost and Maine HealthCost respectively. Using these

A 2010 Commonwealth Fund report states that "APCDs are proving to be powerful tools for all stakeholders in states where they are being used, filling in long-standing gaps in health care information. They include data on diagnoses, procedures, care locations, providers, and provider payments, and offer both baseline and trend data that will guide policymakers and others through the transitions that health care reform will bring in years to come. As with all data sets, there are limitations to APCD data, but capturing information from most if not all of the insured encounters in a state can still create a powerful information source." The report also indicates the challenges APCDs face, despite some positive results. "While APCDs have undeniably proven to be valuable where they are in use, their development and implementation require states to resolve the numerous political and technical challenges associated with large-scale information systems. Such challenges include engaging and educating all major stakeholders, determining governance and funding, identifying data sources, and determining how the data will be managed, stored, and accessed."

sites, both insured and uninsured individuals can compare the prices of various medical services for different providers. Similarly, Minnesota state officials unveiled a new tool for insured consumers to gain access to *average* negotiated rate information on the website, Minnesota Health Scores.

FEDERAL ACTIVITY The federal government can also play a role in transparency. One of the best examples of price transparency in a federal program is the disclosure of drug prices in the Medicare Part D program, signed into law in 2003. For most individuals, the Part D benefit is structured so that an individual pays 100% of the cost of a drug when he or she is in the "donut hole" (after exceeding the initial prescription coverage and before reaching an annual maximum for out-of-pocket costs). Medicare provides an online tool where an individual beneficiary can enter the name and dosage of the drug and a database will provide the beneficiaries with their expected out-of-pocket costs.

Medicare also offers a Hospital Compare website, which allows Medicare beneficiaries to compare the quality of hospitals in their area. The website provides a "snapshot" of hospital quality and includes six aspects of care: timely and effective care; readmissions, complications and death; use of medical imaging; survey of patients' experiences; number of Medicare patients; and Medicare payment. By making this information available on the federally-managed Hospital Compare platform, the federal government has taken a step in the right direction. However, to make the site truly valuable for patients, Medicare needs also to share price data. Finally, the Patient Protection and Affordable Care Act (PPACA) of 2010 includes a provision that requires hospitals to provide charge information to the public annually.[33]

WHAT ARE THE CHALLENGES TO ACHIEVING PRICE TRANSPARENCY?

While our health care system has made significant strides in publicly reporting data on provider performance and quality, purchasers, plans, providers, other vendors, and policy makers need to do more to help price information flow freely, both overall and for specific services. A number of obstacles to achieving this goal exist, including the complexity of the health care marketplace itself. Our health care system has enormous variation in care delivery, different approaches for measuring outcomes, and wide-ranging products and services. The diversity of payers in a market that contract with providers at different rates and serve different populations (e.g. Medicare, Medicaid, individual, group) compounds the complexity. As purchasers, providers and policymakers pursue change, lack of provider competition, health plan restrictions on data use, and policymakers' concern about the "unintended consequences" of price transparency also pose challenges.

LACK OF PROVIDER COMPETITION Lack of provider competition in a market, particularly among hospitals and specialists, makes it easy for some providers to refuse to reveal prices to consumers. The major health plans have attempted to address this by removing so-called "gag clauses" from their contracts or by working with facilities outside of the normal contracting cycle to seek permission to share their price information in transparency tools. Much effort has been made to remove such contractual barriers to transparency, but there are still gaps in the information accessible to consumers, particularly in markets like California. Legislation, such as the California example above, can address this issue – essentially preventing providers from entering into contracts that don't allow plans to share data with plan members or a Medicare Qualified Entity.

HEALTH PLAN RESTRICTIONS ON DATA USE Due to restrictions from health plans, many self-funded purchasers face challenges with using their own claims data to build transparency tools for their consumers. These purchasers receive information and data

Lack of provider competition in the market, particularly among hospitals and specialists, makes it easy for some providers to refuse to reveal prices to consumers.

Purchasers believe that more competition between those developing and offering transparency tools will promote innovation and better serve the needs of consumers in the long run.

from contracted health plans and their data vendors, but still may wish to contract with other parties to build price transparency tools for their consumers. However, some health plans do not allow purchasers to give information to other vendors about the prices the plan paid to providers for the purpose of price transparency, arguing that price information is proprietary and confidential, even though it was the purchaser's funds that paid these claims. With third-party vendors increasing the options in the market, more purchasers are raising the issue of "who owns the data" in private and public dialogues.

This controversy may be less about the law, and more about health plans' interests. Self-funded purchasers, insurers, and third-party data vendors must all adhere to applicable privacy laws and regulations, including HIPAA, ERISA and HITECH. The transfer of data between such parties is protected under these laws and regulations. Health plans, in their effort to be responsive to market demands for greater transparency, are developing more sophisticated and proprietary transparency tools using the claims data. Their investment in these tools is significant and they have concerns that providing claims data to other vendors will introduce or support competing products.

Unfortunately, with this restriction on the data, purchasers and consumers may be losing out. Purchasers who conclude that a plan's tool is not robust or consumer-friendly or meeting their needs in some other way, may want to pursue other options. Purchasers largely believe data about their funds paid to providers belongs to them and that they have the right to provide it to whoever can perform the services they need. Furthermore, purchasers believe that, in the long run, more competition among those developing and offering transparency tools will promote innovation and better serve the needs of consumers.

UNINTENDED CONSEQUENCES OF PRICE TRANSPARENCY While price transparency can help purchasers design value-based benefits and address unwarranted price variation, there are well-founded concerns about the potential unintended, negative consequences of price transparency. For instance, price transparency without quality information could perpetuate consumers' misconception that prices correlate with quality, with some consumers thinking higher-priced care is better. Furthermore, while standard economic theory suggests that price transparency leads to lower and less varied prices, price transparency also has the potential to generate higher prices and anti-competitive provider behavior.

For example, Hospital A could analyze Hospital B's prices across town and decide to negotiate for increases if Hospital B seems able to charge more without sacrificing

volume. Similarly, physicians and hospitals could use price information collectively to set the level of discounts to negotiate with health plans. Further, if all prices are public, it could dilute a health plan's ability to negotiate favorable volume discounts. This could result in higher health care costs for purchasers and consumers, at least in the short term. And finally, price transparency could cause confusion among the general public, at least initially, as individuals' out-of-pocket costs vary with their insurance status, source of coverage (private, public, uninsured), and benefit design. One market-based solution to mitigate this potential unintended consequence is to make sure that consumers have access only to their own relevant pricing information based on their health plan and specific benefit design.

Policymakers can also take steps to remedy these problems. Policymakers can and should use existing laws to monitor marketplace behavior, as they do in other industries, to ensure that providers do not use price data in an anti-competitive manner.

When plans limit access to the claims, price, or reimbursement data necessary to populate robust consumer shopping tools, they disadvantage purchasers and consumers. To minimize or avoid unintended consequences, sharing data to develop transparency tools must be done carefully and constructively. The more health plans and other vendors there are offering tools to meet the demand from large employers and purchasers, the more competition there will be to produce better tools. When plans control the data for competitive or proprietary reasons, they restrict the strategies and tools purchasers can use to control health care costs and enable consumers to maximize their benefits and engage in informed decision-making. As providers, health plans and purchasers make more information on price and quality accessible, consumers will become more educated about value, learning that more expensive care isn't always best.

Policymakers can and should use existing laws to monitor marketplace behavior, as they do in other industries, to ensure that providers do not use price data in an anti-competitive manner.

ACTIONS PURCHASERS CAN TAKE TO DRIVE TRANSPARENCY

Purchasers can and should play a central role in ensuring consumers and their families have access to comprehensive, easy-to-use tools that provide understandable information about health care quality and price. Purchasers can:

1. **Require their contracted health plans to:**
   - Provide easy-to-understand price and quality comparison tools to consumers. (CPR's Health Plan Request for Information, Model Health Plan Contract Language, and Specifications can support and guide this conversation);
   - Help educate consumers about the benefits of using such tools and their functionality; and,
   - Allow purchasers to share their claims data with third-party vendors for building a transparency tool for consumers or for help with claims data analysis and interpretation.
2. **Educate their consumers about how price transparency tools can help them make important decisions about their health care and how to use them:**
   - Use the PBGH cost-calculator "Tip Sheet" to identify tactics to encourage consumers to register for and use their plan's cost calculator tools;
   - Build on price transparency tools with innovative benefit designs and payment reform programs, such as reference pricing and packaged-pricing for specific services like maternity care that will make the price information highly relevant; and,
   - Encourage consumers to ask their physicians and other providers for an estimate of what they will charge before receiving care.

3. **Be vocal about the need for effective price transparency:**
   - Endorse CPR's "Statement on Transparency" and stand behind it in the sourcing, contracting and management of health plans and other vendors (sign on here);
   - Support health plans and other vendors who are developing these tools by sending the message to providers that transparency is important to you and your consumers – their patients; and,
   - Use CPR's Specifications for transparency tools in the development of a new tool or in the evaluation and comparison of existing tools.
4. **Take part in statewide data collection efforts:**
   - Statewide data collection efforts can improve access to credible quality and cost information. A fact sheet prepared by the All-Payer Claims Database Council provides background information. Their website also lists state efforts: http://apcdcouncil.org/;
   - California purchasers can visit www.pbgh.org/CHPI to learn more about the California Healthcare Performance Information System, the new multi-payer claims database in California; and,
   - If gag clauses or other contractual provisions between health plans and providers create barriers to the release of quality and price information in your area, support efforts – voluntary or legislative – to make that information transparent. Write a letter to the involved parties (e.g. hospital CEOs) indicating that you and your consumers want them to make this information available.

CONCLUSION

Purchasers believe making quality and price information transparent to consumers is a powerful building block for supporting them in making more value-oriented choices, which can improve quality and reduce costs for everyone. Yet barriers to price transparency remain, including pushback from providers and limitations on data-sharing by the health plans. Purchasers will continue to encourage health plans to develop robust, consumer-friendly transparency tools and to share data with other vendors so they can do the same. CPR's health plan RFI questions and model contract language can help purchasers to push plans on transparency and related payment reform strategies. Purchasers can also engage in advocacy and regional efforts to collect data, such as all-payer claims databases. Finally, purchasers can use CPR's specifications to compare existing transparency tools and select one that meets their needs. Using these tools, purchasers can foster transparency, driving the health care marketplace closer to meeting the needs of those who use and pay for care.

ABOUT US

Catalyst for Payment Reform is an independent, non-profit corporation working on behalf of large employers to catalyze improvements in how we pay for health services and to promote better and higher-value care in the U.S.

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CATALYST FOR PAYMENT REFORM

Comprehensive Specifications for the Evaluation of Transparency Tools

INTRODUCTION

As health care costs continue to rise, consumers, including employees, their families and dependents, are taking on a growing share of their health care costs. Seeking to implement strategies to help them manage those costs, health care purchasers, including large employers and states, recognize they need to provide consumers with information on both prices and quality along with incentives to seek high-value care. While the health care system has made information about quality more transparent in recent years, much more work needs to be done to advance price transparency and to connect price (particularly consumers' expected out-of-pocket contribution) and quality (especially outcomes measures and other measures of safety, effectiveness, timeliness, efficiency, equity and patient centeredness) data to capture overall value. Health plans and other vendors are developing transparency tools to meet some or all of these needs.

To help purchasers evaluate and compare available tools, CPR developed specifications for optimal transparency tools. These specifications include price, quality, provider information, consumer engagement, treatment-decision support and other features. CPR understands that these tools will evolve over time based on consumer needs and demands and that current tools are unlikely to include all specifications. However, the specifications will support purchasers working with health plans and other vendors to develop tools that meet their needs and those of consumers. We hope they will also spur developers of transparency tools to broaden the scope of providers, services, and markets these tools address.

CPR developed these specifications after reviewing the capabilities of existing tools and with consideration of criteria developed by other organizations (see last page for acknowledgements). The specifications fall into five categories:

- **Scope** – the comprehensiveness of providers, including in-network and out-of-network providers, and service information, including price, quality, and consumer ratings.
- **Utility** – the capability of the tool to facilitate consumer decision making through features that permit comparisons of health care providers' prices, quality, and care settings.
- **Accuracy** – the extent to which consumers can rely on the provider, service, and benefit information.
- **Consumer Experience** – the user-friendly nature of the tool, including the availability of mobile applications and easy-to-find, easy-to-understand information.
- **Data Exchange, Reporting and Evaluation** – the extent to which claims data are exchanged with purchasers according to all privacy laws, the ability of purchasers to use the data with third-party vendors, regular reporting to the purchaser, ongoing improvement of the tool, and the ability of users to rate the tool.

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INSTRUCTIONS

As purchasers address consumers' need for transparent price and quality data, they will be faced with comparing tools with various options and features; some of these are more important than others. At a minimum, CPR recommends purchasers use its "Core Transparency Tool Specifications" to compare and evaluate tools. For a more comprehensive, thorough evaluation of a transparency tool's full capabilities, CPR recommends using the "Expanded Transparency Tool Specifications."

Purchasers can print this document to assist with assessing or comparing the capabilities of various transparency tools offered by health plans or other vendors.

TRANSPARENCY TOOL SPECIFICATIONS

SCOPE

CORE SPECIFICATIONS

YES NO

☐ ☐ **Comprehensive provider coverage**
At a minimum, the tool should include information on all network physicians and hospitals. Ideally, the tool would also include information on out-of-network physicians and hospitals.

☐ ☐ **Comprehensive service coverage**
Includes all medications, services, and procedures (inpatient, outpatient, diagnostic, office visits, etc.).

☐ ☐ **Meaningful provider information**
Includes provider performance (e.g. physician recognition awards, quality indicators for the individual physician or his/her affiliated medical group, patient experience), contact information (e.g. phone, address, email, access hours), whether or not accepting new patients, credentials (e.g. board certifications, education, relevant specialty information), Maintenance of Certification, languages spoken, and network status (in-network, out-of-network).

☐ ☐ **Meaningful service information**
Includes, at a minimum, relevant information on quality (including outcomes measures and other measures of safety, effectiveness, timeliness, efficiency, and equity), price (including out-of-pocket contribution and total price), and patient experience to support consumers seeking value-oriented care.

If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.

If ***NO***, the core specifications *are not* met, talk to your vendor or consider other tool options.

EXPANDED SPECIFICATIONS

YES NO

☐ ☐ **Consumer financial liability**
Displays consumer financial liability based on remaining deductible, copay, and out-of-pocket maximum to show likely price of care at the moment of query.

☐ ☐ **Integrated savings and account balances**
Savings and account balances are integrated across health savings accounts (HSA, HRA, FSA) so patients know amount of funds available to pay for services.

☐ ☐ **Consumer engagement tools**
Additional features available to engage consumers, such as real-time messaging, email exchange between provider/plan and consumer, savings calculators, highlighting of high quality providers, etc.

☐ ☐ **Addresses health literacy**
Includes lay terms when describing services, as well as detailed medical explanations.

UTILITY

CORE SPECIFICATIONS

YES NO

☐ ☐ **Interface**
Users can obtain price, quality, provider, and personalized information (e.g. account balances, benefit design, etc.) through an intuitive, easy-to-navigate interface.

If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.

If ***NO***, the core specifications *are not* met, talk to your vendor or consider other tool options.

EXPANDED SPECIFICATIONS

YES NO

☐ ☐ **Flexible search capability**
Allows various search capabilities (e.g. by procedure category, specialty, centers of excellence, accountable care organization, PCMH, location, price, quality, provider name, and in-network vs. out-of-network).

☐ ☐ **Compares alternative health care settings**
Allows for comparison of alternative care settings (e.g. ER vs. urgent care vs. retail clinic).

☐ ☐ **Emphasis on high-value providers**
Clearly identifies higher-value providers using easy-to-understand and easy-to-identify words or symbols. The methodology behind the value distinction should be made available to the consumer.

☐ ☐ **Consumers can see how well they shop**
Provides consumers with real-time, annual, personalized scorecards about their own health activities, including use of high-quality/efficient providers, price of services, in- and out-of-network use, use of services, and overall financial impact of choices compared to benchmarks where possible.

☐ ☐ **Consumers have access to clinical support**
Users have access to live telephonic and online patient education and decision support (e.g. diabetes information, treatment options, etc.), financial guidance (e.g. how to use the benefit efficiently), reference pricing, and other programs (e.g. centers of excellence, tiered networks) from people trained to explain health and benefits.

☐ ☐ **Appointment scheduling**
Provides assistance with online appointment scheduling and personalized calendars that display and alert user of upcoming appointments and the need for preventive screenings.

☐ ☐ **GPS capability**
Provides users with maps and directions to provider offices.

☐ ☐ **Information security**
Fully compliant with all data and information security methods (HIPAA compliant at a minimum).

UTILITY

CORE SPECIFICATIONS

YES NO

☐ ☐ **Presentation of information**
Presents information in a format that facilitates informed decision-making by consumers, including the ability to compare providers' prices, quality, and care settings.

If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.

If ***NO***, the core specifications *are not* met, talk to your vendor or consider other tool options.

EXPANDED SPECIFICATIONS

YES NO

☐ ☐ **Provider rating**
Allows users to rate and review providers and publishes their ratings and reviews to make them easily accessible to all users of the tool.

☐ ☐ **Mail-order medications**
Allows users to fill or refill prescriptions online to be delivered by mail.

☐ ☐ **Procedure labels**
Procedures are displayed simultaneously by both common name and procedure code, including ICD-9 & ICD-10 when available.

☐ ☐ **Customized user profiles**
Allows consumers to save user-specific information, such as demographic information, benefit design, status of deductibles, coinsurance, account balances (HRA, HSA), copayments, location, provider preferences (e.g. name, gender, experience), treatment preferences, EHR, historical usage, benefit design, status of deductibles, and user-generated notes.

☐ ☐ **Includes physician-hospital relations**
Displays physician and hospital relationships where physicians have privileges for applicable specialties and diagnoses/procedures.

☐ ☐ **Integration with Patient Medical Record (PMR)**
Allows for and automates the transfer of provider cost and quality information to the PMR.

ACCURACY

CORE SPECIFICATIONS

YES NO

☐ ☐ **Timely and up-to-date**
Service (e.g. price and quality) and provider (e.g. location and contact) information is accurate and updated regularly to ensure accuracy.

☐ ☐ **Price information**
Price information reflects the total out-of-pocket expense (including remaining deductible, copay, and out-of-pocket maximum reached) for a specific service at the moment of query, based on the individual consumer's benefit plan and provider-specific contracts (both negotiated in-network and expected out-of-network). The price should reflect the actual price and not the average price for a region.

☐ ☐ **Quality information**
Quality information is based on direct outcome measures when available, and otherwise is based on nationally-endorsed, consensus-based process or structural measures. Performance measurement should follow the criteria outlined in the *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs* (the *Patient Charter*) found at http://healthcare-disclosure.org/docs/files/PatientCharter.pdf.

If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.

If ***NO***, the core specifications *are not* met, talk to your vendor or consider other tool options.

EXPANDED SPECIFICATIONS

YES NO

Price sources
If contracted rates are not used, price information should be based on the following:

☐ ☐ 1. Historical prices: Physicians For physicians (groups and individuals), price information based on actual unit price derived from historical claims.

☐ ☐ 2. Historical prices: Hospitals For hospitals (systems and individual), price information based on actual unit price derived from historical claims.

☐ ☐ 3. Historical prices: Pharmacy For pharmacy services price information based on actual unit price.

☐ ☐ **Bundled services**
For complex services (e.g. knee replacement), price, displayed as a single price estimate, reflects all services expected to be included.

☐ ☐ **Consumer-specific estimates**
Price estimates reflect users' health status and the complexity of the level of services when possible.

☐ ☐ **Quality information is actionable/reliable**
Quality data is provider-specific and is only displayed when a sample size yields a confidence level of 90% or greater.

☐ ☐ **Process measures of quality**
When no outcomes data are available, quality information is based on nationally-endorsed, consensus-based process measures, or measures proven to lead to improved clinical outcomes (e.g. CMS quality metrics, Leapfrog quality indicators and other measures developed in alignment with the *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs)*.

☐ ☐ **Accurate and timely consumer information**
All consumer-specific personalized information included in tool (e.g. demographic information, benefit design, status of deductibles, coinsurance, account balances [HRA, HSA], copayments, provider preferences [e.g. name, gender, experience], treatment preferences, EHR, historical usage, and user-generated notes) is **accurate** and **real time**.

☐ ☐ **Rationale for missing information**
When accurate information is not available, the tool provides an easy-to-understand explanation.

CONSUMER EXPERIENCE

CORE SPECIFICATIONS

YES NO

☐ ☐ **Understandable to the consumer**
Tool is comprehensive, simple, and uses commonly understood language and symbols that make relevant information obvious and coherent to the user.

☐ ☐ **Technological platforms**
Information is accessible through web-based and mobile applications as well as through telephone customer service.

If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.

If ***NO***, the core specifications *are not* met, talk to your vendor or consider other tool options.

EXPANDED SPECIFICATIONS

YES NO

☐ ☐ **Access to tool**
Tool is easy to identify by users from website home-page and access is secure.

☐ ☐ **Easily accessible clinical information**
Treatment options and potential alternatives, including care setting options, are easy to identify and access. Also provides online treatment decision support and access to other live support.

☐ ☐ **Resources to obtain medical records**
Provides consumers with resources to obtain their personal medical information and the ability to keep it current to help consumers personally manage their care and assist in decision-making.

☐ ☐ **Printability**
Displays and information are available in a printable (e.g. PDF) format.

☐ ☐ **Integrates decision support with financial and benefit options**
Connects information to other relevant resources when members are considering care options, including but not limited to, open enrollment, benefit coverage materials, health-risk assessments, customer support, etc.

☐ ☐ **Accommodates all consumers**
Accommodates individuals with special needs and/or limited technological access.

DATA EXCHANGE, REPORTING AND EVALUATION

CORE SPECIFICATIONS

YES NO

☐ ☐ **Claims data access**
Contracts between health plans and purchasers have no restrictions on a purchaser's access to their claims data (within the scope of all relevant privacy laws) and book of business rates for any given service or bundle of services paid to any provider or network of providers.

☐ ☐ **Data sharing with other vendors**
Contracts between purchasers and plans should permit the purchaser to receive claims data from the plan and share that data with any third-party vendor to develop consumer transparency tools or to assist with data interpretation.

If ***YES***, the core specifications *are* met, consider evaluating the expanded specifications.

If ***NO***, the core specifications *are not* met, talk to your vendor or consider other tool options.

EXPANDED SPECIFICATIONS

YES NO

☐ ☐ **Data Format**
Data are maintained by the health plan or third-party vendor for future purposes, including audits and regular tool improvement.

☐ ☐ **Utilization Reporting (Quality and Savings)**
Vendors should prepare reports to the purchaser during agreed upon intervals on the utilization of quality and savings information. Quality reports should include data on consumers' use of quality-related resources available in the tool. Savings reports should include information on the accuracy of the price data, and measure/evaluate a purchaser's specific savings attributable to consumers' use of the tool. Such reports should also identify opportunities to overcome barriers to utilization and efficacy.

☐ ☐ **Tool evolution**
Vendors routinely monitor the use of the transparency tool and make improvements based on usage data and feedback from users. Vendors should also update the tool based on online consumer trends.

ACKNOWLEDGEMENTS

These specifications were developed after reviewing multiple sources of information and tools related to price transparency. Sources include information from: government agencies; quality organizations; other business coalitions; health plans; vendors; employer contracts; and the Catalyst for Payment Reform health plan RFI and contract language.

CATALYST FOR PAYMENT REFORM

HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE INC

Report Card on State Price Transparency Laws

March 18, 2013

Dear Colleagues,

As health care costs continue to rise, consumers are increasingly being required to take on a growing share. To underscore that point, the most recent survey by Mercer shows that close to two-thirds of all large employers offer a high deductible/high co-insurance health plan and that close to 20 percent of all commercially insured health plan members are enrolled in such plans. In this environment, it is only fair and logical to ensure that consumers have the necessary quality and price information to make informed decisions about where to seek health care. We have made progress sharing information about the quality of care, with organizations like Bridges to Excellence and The Leapfrog Group leading the way and federal and state governments getting in on the act. But with recent studies showing us that the price for an identical procedure within a market can vary seven-fold with no demonstrable difference in quality, price transparency is more important than ever.

While the private sector has made progress recently in making prices more available to consumers, there are still large gaps. States can play an important role in ensuring that consumers have access to both quality and price information by setting policies and implementing laws that advance transparency. The most comprehensive, consumer-friendly laws ensure ready access to information and data about a broad range of providers and services.

This Report Card on State Price Transparency Laws represents a joint effort between Catalyst for Payment Reform and the Health Care Incentives Improvement Institute to examine existing transparency laws in all 50 states and grade them, using well-defined criteria, on how well they support the information needs of consumers. The Methodology section of this report contains detail about these criteria.

We hope the Report Card will inform advocates, lawmakers and policy experts about today's best practices or what constitutes a top grade and, over time, generate improvements in public policies across the nation. American consumers deserve to have as much information about the quality and price of their health care as they do about restaurants, cars, and household appliances.

Sincerely,

Francois de Brantes, MS, MBA
Executive Director
Health Care Incentives Improvement Institute

Suzanne Delbanco, Ph.D.
Executive Director
Catalyst for Payment Reform

I. METHODOLOGY

Catalyst for Payment Reform (CPR) and the Health Care Incentives Improvement Institute (HCI[3]) teamed up to review state-specific laws focused on price transparency for health care. The review generated two products: (1) a Report Card on State Price Transparency Laws and (2) a reference table that provides the details of the price transparency laws for each state.

CPR and HCI[3] examined statutes and enacted bills using WestLawNext database, the National Conference on State Legislature's website, and websites from various state legislatures, among other sources.

This research revealed a wide variety of state laws, with two common and critical elements: (1) varying levels of price information and (2) varying levels of public access to that information. Using that continuum, the research team established levels of price transparency and scoring criteria.

Levels of Price Transparency:

- Pricing information reported to the State only
- Pricing information available upon request by an individual consumer
- Pricing information available in a public report
- Pricing information available via a public website

Scoring Criteria:

- Scope of price: including charges, average charge, amount paid by the insurer and amount paid by the consumer (allowed amount)
- Scope of services covered under the law including: all medical services, inpatient services only, outpatient services only or the most common inpatient and outpatient services
- Scope of providers affected by the law including: hospitals, physicians, and surgical centers

Next, the team developed a scoring matrix (shown on following page), which allocates points based on level of price transparency and scope of price, services, and providers.

We evaluated each level of price transparency laws for scope of price, services, and providers. For example, if laws required pricing information (both paid amounts and charges) to be posted on a public website for all inpatient and outpatient services across all hospitals and providers, the state received full credit (50 out of 50 possible points) for that level of transparency. However, if the laws required only charges to be posted for the most common hospital discharges across a subset of hospitals, the state received substantially fewer points (15 out of 50 possible points). We calculated a score for each level separately and then summed for a total score out of 100 possible points. Every state received a cumulative additive score, taking into account all relevant laws passed in that state. Thus, grades do not reflect individual statutes or bills but rather each state's overall legislative effort toward price transparency for health care.

The objective of this research was to determine how much pricing information each state makes accessible to the consumer. As a result, we allocated more points to states with laws requiring that information be posted on a public website than to those with provisions for releasing a public report, making the information available upon request, and only

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ACKNOWLEDGMENTS

Special thanks to Elizabeth Bailey, MPH, Program Implementation Leader, HCI3, and Emilio Galan, Special Initiatives Analyst, Catalyst for Payment Reform, for their research and dedication to this project.

specific to both what was paid for a service and what was charged for that service is more meaningful than only releasing what was charged. Charges often are of little value to consumers; the amount that is actually paid for the service, particularly the amount that the consumer is responsible for paying, provides the most actionable information. Similarly, releasing pricing information for all inpatient and outpatient services and for all hospitals and providers, rather than just the most common services or a subset of providers, is more meaningful to the consumer. As a result, we allotted a higher point value to the broader scope of services/providers.

				SUBTOTAL	TOTAL	GRADE
Provision for publishing a report to the state only			**1 (weight)**	10	100	A
Scope of Price Legislated (three levels, can only have 1 score out of 3)	Paid Amounts and Charges	4	4			
	Paid Amounts	3				
	Charges	1				
Scope of Services Legislated (three levels, can only have 1 score out of 3)	All IP and OP	3	3			
	All IP or OP	2				
	Most common IP or OP	1				
Scope of Health Care Providers Legislated (three levels, can only have 1 score out of 3)	All hospitals and providers	3	3			
	All hospitals or providers	2				
	Subset of hospitals/providers	1				
Ability for patient to request pricing information prior to rendering of services			**2 (weight)**	20		
Scope of Price Legislated (three levels, can only have 1 score out of 3)	Paid Amounts and Charges	4	8			
	Paid Amounts	3				
	Charges	1				
Scope of Services Legislated (three levels, can only have 1 score out of 3)	All IP and OP	3	6			
	All IP or OP	2				
	Most common IP or OP	1				
Scope of Health Care Providers Legislated (three levels, can only have 1 score out of 3)	All hospitals and providers	3	6			
	All hospitals or providers	2				
	Subset of hospitals/providers	1				
Provision for publishing a public report on pricing information			**2 (weight)**	20		
Scope of Price Legislated (three levels, can only have 1 score out of 3)	Paid Amounts and Charges	4	8			
	Paid Amounts	3				
	Charges	1				
Scope of Services Legislated (three levels, can only have 1 score out of 3)	All IP and OP	3	6			
	All IP or OP	2				
	Most common IP or OP	1				
Scope of Health Care Providers Legislated (three levels, can only have 1 score out of 3)	All hospitals and providers	3	6			
	All hospitals or providers	2				
	Subset of hospitals/providers	1				
Provision for posting pricing information on a public website			**5 (weight)**	50		
Scope of Price Legislated (three levels, can only have 1 score out of 3)	Paid Amounts and Charges	4	20			
	Paid Amounts	3				
	Charges	1				
Scope of Services Legislated (three levels, can only have 1 score out of 3)	All IP and OP	3	15			
	All IP or OP	2				
	Most common IP or OP	1				
Scope of Health Care Providers Legislated (three levels, can only have 1 score out of 3)	All hospitals and providers	3	15			
	All hospitals or providers	2				
	Subset of hospitals/providers	1				

While no state has implemented laws that meet all of our criteria, we graded on a curve to acknowledge the states with the most advanced laws to date. We anticipate that this curve will shift as transparency becomes more of a priority nationally. We based the letter grades on the following scores:

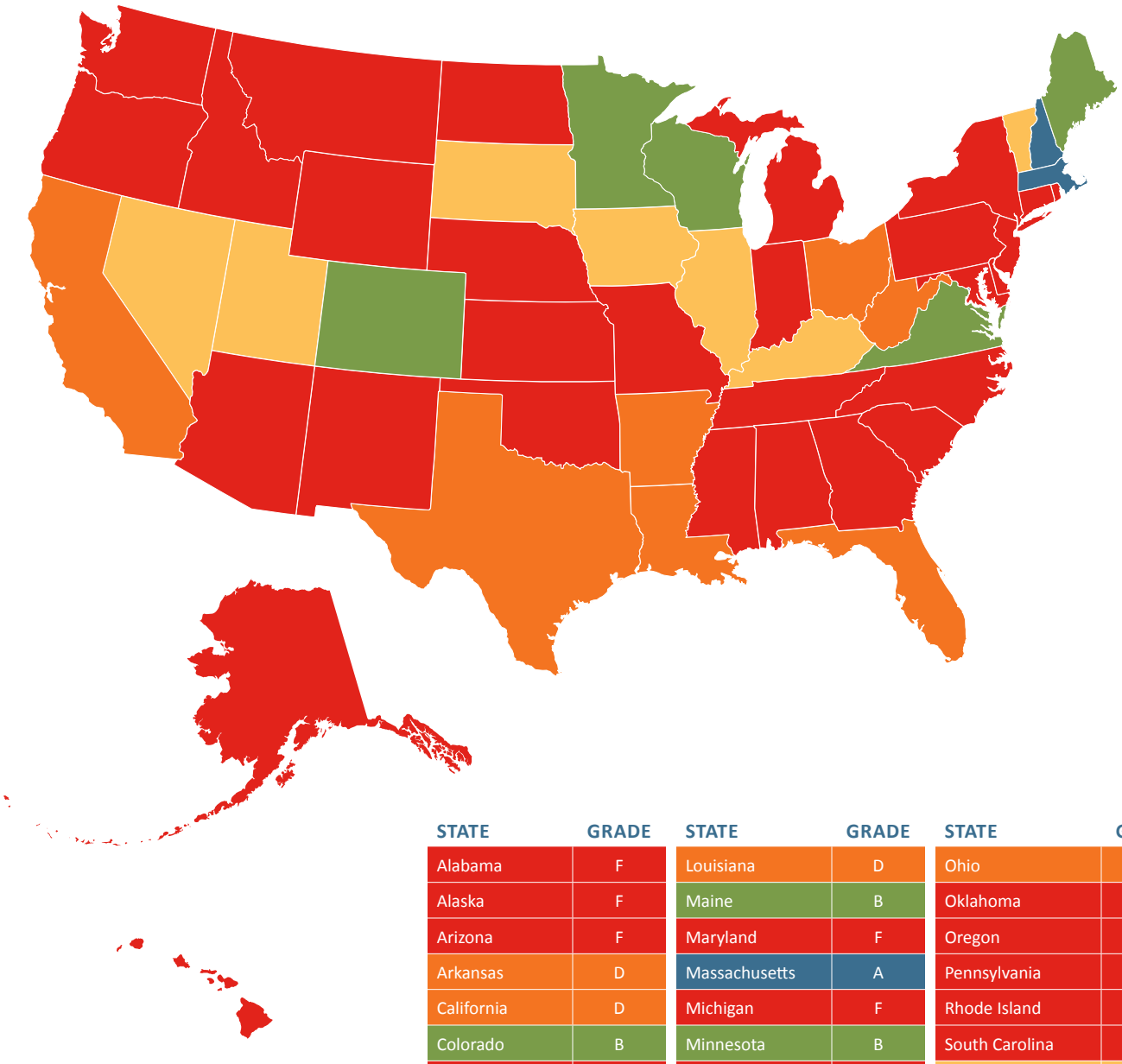
GRADE	FROM	TO
A	60%	100%
B	50%	59%
C	40%	49%
D	30%	39%
F	0%	29%

Limitations of this research include (1) variation in definitions among states and (2) accounting for the difference between laws and execution. Numerous permutations exist in the ways states define terms, such as the term "health care provider" or what is included in a "public report." Many times these public reports, even when developed for the explicit purpose of enabling consumers to make informed decisions, do not contain the resolution of information needed to understand a specific provider's price. Instead, public reports may contain aggregate or average charges for all providers for a specific service. Interested readers should refer to the statute text and example reports, which are hyperlinked in the "Reference Table." The second limitation is accounting for the difference between laws and execution. A website intended for consumer use may be legislated but not easily identifiable or actionable, while in other cases, such a website was not legislated but nonetheless developed by the state or an independent party, often the state's hospital association. These considerations were addressed on a state by state basis with all relevant details present or hyperlinked in the Reference Table.

Resources permitting, CPR and HCI[3] will partner again next year to update this state report card. We anticipate that we will raise the scoring thresholds for each letter grade at that time.

II. 50 STATE REPORT CARD ON PRICE TRANSPARENCY LAWS

Figure 1: Map Overlay



STATE	GRADE	STATE	GRADE	STATE	GRADE
Alabama	F	Louisiana	D	Ohio	D
Alaska	F	Maine	B	Oklahoma	F
Arizona	F	Maryland	F	Oregon	F
Arkansas	D	Massachusetts	A	Pennsylvania	F
California	D	Michigan	F	Rhode Island	F
Colorado	B	Minnesota	B	South Carolina	F
Connecticut	F	Mississippi	F	South Dakota	C
Delaware	F	Missouri	F	Tennessee	F
Florida	D	Montana	F	Texas	D
Georgia	F	Nebraska	F	Utah	C
Hawaii	F	Nevada	C	Vermont	C
Idaho	F	New Hampshire	A	Virginia	B
Illinois	C	New Jersey	F	Washington	F
Indiana	F	New Mexico	F	West Virginia	D
Iowa	C	New York	F	Wisconsin	B
Kansas	F	North Carolina	F	Wyoming	F
Kentucky	C	North Dakota	F		

III. SIMPLIFIED SCORING AND GRADES BY STATE

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
AK	State Only										F
	Upon Request										
	Report										
	Website										
AL	State Only										F
	Upon Request										
	Report										
	Website										
AR	State Only		✓				✓			✓	D
	Upon Request										
	Report		✓				✓			✓	
	Website		✓				✓			✓	
AZ	State Only			✓			✓		✓		F
	Upon Request		✓				✓			✓	
	Report			✓			✓		✓		
	Website										
CA	State Only		✓				✓	✓		✓	D
	Upon Request			✓			✓	✓		✓	
	Report										
	Website		✓				✓			✓	
CO	State Only			✓		✓	✓			✓	B
	Upon Request		✓				✓			✓	
	Report										
	Website		✓	✓		✓	✓			✓	
CT	State Only	✓				✓	✓		✓		F
	Upon Request	✓					✓			✓	
	Report										
	Website										
DE	State Only		✓				✓		✓		F
	Upon Request										
	Report		✓				✓		✓		
	Website										
FL	State Only		✓				✓		✓		D
	Upon Request			✓			✓			✓	
	Report										
	Website		✓				✓			✓	
GA	State Only	✓					✓		✓		F
	Upon Request										
	Report										
	Website										
HI	State Only										F
	Upon Request										
	Report										
	Website										

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
IA	State Only		✓				✓	✓			C
	Upon Request										
	Report										
	Website		✓				✓	✓		✓	
ID	State Only										F
	Upon Request										
	Report										
	Website										
IL	State Only		✓				✓	✓			C
	Upon Request		✓				✓		✓		
	Report		✓				✓	✓			
	Website		✓				✓			✓	
IN	State Only		✓				✓		✓		F
	Upon Request		✓				✓		✓		
	Report		✓				✓		✓		
	Website										
KS	State Only	✓					✓		✓		F
	Upon Request										
	Report										
	Website										
KY	State Only	✓					✓		✓		C
	Upon Request										
	Report	✓					✓		✓		
	Website	✓					✓		✓		
LA	State Only	✓					✓		✓		D
	Upon Request										
	Report										
	Website	✓					✓		✓		
MA	State Only	✓			✓			✓			A
	Upon Request				✓				✓		
	Report		✓				✓	✓			
	Website	✓				✓				✓	
MD	State Only		✓				✓		✓		F
	Upon Request										
	Report		✓				✓		✓		
	Website										
ME	State Only	✓			✓					✓	B
	Upon Request	✓				✓				✓	
	Report										
	Website		✓		✓					✓	
MI	State Only										F
	Upon Request										
	Report										
	Website										

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
MN	State Only	✓			✓			✓			B
	Upon Request			✓			✓		✓		
	Report		✓				✓		✓		
	Website		✓				✓			✓	
MO	State Only										F
	Upon Request										
	Report										
	Website										
MS	State Only										F
	Upon Request										
	Report										
	Website										
MT	State Only										F
	Upon Request										
	Report										
	Website		✓				✓	✓			
NC	State Only		✓				✓			✓	F
	Upon Request		✓				✓			✓	
	Report										
	Website										
ND	State Only	✓					✓	✓			F
	Upon Request										
	Report	✓					✓			✓	
	Website										
NE	State Only										F
	Upon Request	✓					✓		✓		
	Report										
	Website										
NH	State Only	✓			✓			✓			A
	Upon Request	✓			✓					✓	
	Report										
	Website	✓			✓					✓	
NJ	State Only		✓		✓				✓		F
	Upon Request										
	Report		✓		✓				✓		
	Website										
NM	State Only		✓				✓		✓		F
	Upon Request										
	Report		✓				✓		✓		
	Website										
NV	State Only		✓				✓			✓	C
	Upon Request		✓				✓			✓	
	Report		✓				✓			✓	
	Website		✓				✓			✓	

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
NY	State Only	✓					✓			✓	F
	Upon Request										
	Report	✓					✓			✓	
	Website										
OH	State Only		✓				✓		✓		D
	Upon Request		✓				✓			✓	
	Report										
	Website		✓				✓		✓		
OK	State Only		✓		✓				✓		F
	Upon Request										
	Report										
	Website										
OR	State Only	✓					✓		✓		F
	Upon Request										
	Report	✓					✓		✓		
	Website										
PA	State Only	✓			✓				✓		F
	Upon Request										
	Report	✓			✓				✓		
	Website										
RI	State Only	✓			✓				✓		F
	Upon Request										
	Report	✓					✓		✓		
	Website										
SC	State Only		✓				✓	✓			F
	Upon Request										
	Report		✓				✓		✓		
	Website										
SD	State Only		✓				✓		✓		C
	Upon Request		✓				✓		✓		
	Report		✓				✓			✓	
	Website		✓				✓			✓	
TN	State Only	✓					✓	✓			F
	Upon Request										
	Report	✓					✓	✓			
	Website										
TX	State Only	✓					✓	✓			D
	Upon Request	✓					✓	✓			
	Report	✓					✓	✓			
	Website										
UT	State Only	✓					✓		✓		C
	Upon Request										
	Report	✓					✓		✓		
	Website	✓					✓		✓		

State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
VA	State Only	✓			✓			✓			B
	Upon Request										
	Report	✓			✓				✓		
	Website	✓					✓			✓	
VT	State Only	✓					✓	✓			C
	Upon Request										
	Report	✓					✓			✓	
	Website	✓					✓			✓	
WA	State Only										F
	Upon Request	✓					✓	✓			
	Report										
	Website										
WI	State Only				✓				✓		B
	Upon Request	✓					✓	✓			
	Report		✓				✓		✓		
	Website		✓				✓			✓	
WV	State Only	✓					✓		✓		D
	Upon Request		✓				✓	✓			
	Report	✓					✓		✓		
	Website										
WY	State Only										F
	Upon Request										
	Report										
	Website		✓				✓	✓			

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Arizona	STATUTE(S): Arizona Revised Statutes § 36-125.05 ENACTED BILL(S): Added: 1983; Amended: S.B. 1201 (1988), S.B. 1486 (1988), S.B. 1086 (1990), S.B. 1352 (1994), H.B. 2048 (1996), S.B. 1142 (2005), H.B. 2150 (2010)	Added: 1983 Amended: 1988, 1990, 1994, 2005, 2010	"hospitals [except] state hospitals"		"The average charge per day [and] The average charge per confinement"		"all inpatient services"	"[report to] the department"		"All reports filed pursuant to this section are open to public inspection"	
	STATUTE(S): Arizona Revised Statutes § 36-125.05 ENACTED BILL(S): Added: 1983; Amended: S.B. 1201 (1988),S.B. 1486 (1988), S.B. 1086 (1990), S.B. 1352 (1994), H.B. 2048 (1996), S.B. 1142 (2005), H.B. 2150 (2010)	Added: 1983 Amended: 1988, 1990, 1996, 2005, 2010	"Emergency departments"		"Charges for services"		"outpatient services"	"[report to] the department"		"All reports filed pursuant to this section are open to public inspection"	
	STATUTE(S): Arizona Revised Statutes § 36-125.06 ENACTED BILL(S): Added: 1983; Amended: S.B. 1086 (1990), H.B. 2048 (1996), S.B. 1230 (2000), S.B. 1142 (2005)	Added: 1983 Amended: 1990, 1996, 2000, 2005	"hospitals and emergency departments"		"average charges per confinement"		"the most common diagnoses and procedures for inpatient and emergency department"		"shall make available in its reception area a sufficient number of these brochures for free distribution of one copy to each individual requesting a copy"	"The director shall publish a comparative report"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Arizona	STATUTE(S): Arizona Revised Statutes § 36-436 ENACTED BILL(S): Added: 1971; Amended: S.B. 1355 (1989), S.B. 1352 (1994)	Added: 1971 Amended: 1989, 1994	"hospital or nursing care institution"		"schedule of its rates and charges"		"all services performed and commodities furnished"	"file […] with the director"	"posted in a conspicuous place in the reception area of each [and] Another copy also shall be kept in the reception area and be available for inspection by the public at all times upon request"	"publish information"	
	STATUTE(S): Arizona Revised Statutes § 36-436.03 ENACTED BILL(S): Added: S.B. 1352 (1994)	Added: 1994	"A home health agency, supervisory care home and a hospice"		"a copy of the institution's rates and charges"				"to the public on request"	"report"	
Arkansas	STATUTE(S): Arkansas Code §§ 20-7-303, 4, 5 ENACTED BILL(S): Added: S.B. 596 (1995) Amended: H.B. 1470 (2005), H.B. 1513 (2007)	Added: 1995 Amended: 2005, 2007	"All hospitals and outpatient surgery centers"		"health data" AND "price […] information"			"collected by the Division of Health of the Department of Health and Human Services"		"disseminate"	"provide data to the Arkansas Hospital Association for its price transparency and consumer-driven health care project"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
California	STATUTE(S): California Health and Safety Code §1339.51, §1339.55 ENACTED BILL(S): Added: A.B. 1627 §6 (2003)	Added: 203	"hospital[s]" except "small and rural hospital[s]"		"charge description master"				"shall make a written […] copy available at the hospital location." AND "shall post a clear and conspicuous notice in its emergency department, if any, in its admissions office, and in its billing office that informs patients that the hospital's charge description master is available"		[…] electronic copy […] by posting an electronic copy […] on the hospital's Internet Web site"
	STATUTE(S): California Health and Safety Code §1339.56 ENACTED BILL(S): Added: A.B. 1627 §6 (2003); Amended: by A.B. 1045 §1 (2005)	Added: 2003	"each hospital"		"average charges"		"25 common outpatient procedures" and "25 most commonly performed inpatient procedures"	"submit annually to the office"	"shall provide a copy […] to any person upon request"		"the office shall publish this information on its Internet Web site"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
STATE	Laws	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
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California	STATUTE(S): California Health and Safety Code §1339.585 ENACTED BILL(S): Added: A.B. 1045 §1 (2005)	Added: 2005	"hospital"		"written estimate of the amount the hospital will require the person to pay […] based on an average length of stay and services provided for the person's diagnosis"		"for health care services, procedures, and supplies […] does not apply to emergency services"		"Upon the request of a person without health coverage"		
	STATUTE(S): California Health and Safety Code §128735 ENACTED BILL(S): Added: S.B. 1360 §5 (1995); Amended: S.B. 1659 §2 (1996), S.B. 1973 §8 (1998), S.B. 680 §2 (2001), S.B. 1498 §163 (2008)	Added: 1995 Amended: 1996, 1998, 2001, 2008	"Every organization that operates, conducts, or maintains a health facility"		"Total charges"			"submit annually to the office"			
Colorado	STATUTE(S): Colorado Revised Statutes §10-16-133 ENACTED BILL(S): Added: H.B. 08-1385 §1 (2008)	Added: 2008		"each carrier"	"information […] useful to consumers and purchasers of health care insurance"				"alternative methods of making the consumer guide accessible to consumers who do not have internet access"		"maintain a consumer guide on the division of insurance web site"

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
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Colorado	STATUTE(S): Colorado Revised Statutes §10-16-111 §1 ENACTED BILL(S): Added: S.B. 92-104 §1 (1992); Amended: S.B. 92-90 §113 (1992)	Added: 1992 Amended: 1992	"Nonprofit hospital, medical-surgical, and health service corporations"	"all insurance companies"		"amounts actually paid"	"for hospital, medical-surgical, and other health services"	"file annually with the commissioner"			
	STATUTE(S): Colorado Revised Statutes §10-16-111 §4 ENACTED BILL(S): Added: H.B. 08-1389 §9 (2008)	Added: 2008		"all carriers"	"medical provider price increases" AND "pharmaceutical price increases"	"The cost of providing or arranging health care services"		"file annually with the commissioner"			"publish the information on the division's web site"
	STATUTE(S): Colorado Revised Statutes §25.5-6-202 ENACTED BILL(S): Added: S.B. 06–219 (2006); Amended: H.B. 08–1114 (2008), S.B. 09-263 (2009), H.B. 10-1324 (2010), H.B. 10-1379 (2010), S.B. 11-215 (2011), H.B. 12-1340 (2012)	Added: 2006 Amended: 2009, 2010, 2011, 2012	"each nursing facility provider"		"cost reports"			"filed with the state department"			
	STATUTE(S): Colorado Revised Statutes §6-20-101 ENACTED BILL(S): Added: S.B. 03-015 (2003); Amended: S.B. 04-239 (2004)	Added: 2003 Amended: 2011	"each hospital"		"Average facility charge […] the average charge information"		"Frequently performed inpatient procedure" (explicitly excludes emergency care)		"disclose to a person seeking care or treatment"		

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Colorado	STATUTE(S): Colorado Revised Statutes §25-3-705 ENACTED BILL(S): Added: H.B. 08-1393 (2008); Amended: H.B. 1303 (2011)	Added: 2008 Amended: 2011	"each hospital"		"Mean charge"		"the top twenty-five diagnostic-related groups with more than ten occurrences"	"shall report annually to the association of hospitals"			"division of insurance web site" AND "shall be made available on the [Colorado Hospital Association's] web site in a manner that allows consumers to conduct an interactive search to view and compare the information for specific hospitals"
	STATUTE(S): Colorado Revised Statutes §10-16-134 ENACTED BILL(S): Added: H.B. 08-1393 (2008)	Added: 2008		"each carrier"		"average reimbursement rates"	"for the average inpatient day […]the twenty-five most common inpatient procedures"	"submit to the division"			"division of insurance web site" AND "shall ensure that the [Colorado Hospital Association's] web site and information is easy to navigate, contains consumer-friendly language"

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Connecticut	STATUTE(S): Connecticut General Statutes §20-7a ENACTED BILL(S): Added: 1973 Amended: S.H.B. 7214 (1991), S.H.B. 5139 (1992), S.H.B. 6713 (2005), S.H.B. 5820 (2006), H.B. 6678 (2009), H.B. 5292 (2010)	Added: 1973 Amended: 1991, 1992, 2005, 2006, 2009, 2010	"Any practitioner of the healing arts who agrees with a clinical laboratory, either private or hospital, to make payments to such a laboratory for [patients'] tests…"		"amounts charged by such laboratory for individual tests or test series and the amount of his procurement or processing charge"				"shall disclose on the bills to patients or third party payors"		
	STATUTE(S): Connecticut General Statutes §20-7b ENACTED BILL(S): Added: 1973 Amended: S.H.B. 7214 (1991), S.H.B. 5139 (1992), S.H.B. 6713 (2005), S.H.B. 5820 (2006), H.B. 6678 (2009), H.B. 5292 (2010)	Added: 1973 Amended: 1991, 1992, 2005, 2006, 2009, 2010	"Each practitioner of the healing arts"		"approximate range of costs"		"test[s] to aid in the diagnosis"		"inform the patient"		
	STATUTE(S): Connecticut General Statutes §19a-613 ENACTED BILL(S): Added: H.B. 6002 (1994); Amended: H.B. 6002 (1994), S.B. 1164 (1995), S.B. 572 (1998), S.B. 547 (1998), S.B. 1373 (1999), H.B 6802 (2009)	Added: 1994 Amended: 1994, 1995, 1998, 1999, 2009	"health care facilities or institutions"		"Patient-level outpatient data"		"outpatient data"	Collected by "The Office of Health Care Access"			

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Connecticut	STATUTE(S): Connecticut General Statutes §19a-646 ENACTED BILL(S): Added: 1984; Amended: H.B. 6002 (1994), S.B. 1164 (1995), S.H.B. 5154 (2002), H.B. 5321 (2012)	Added: 1984 Amended: 1994, 1995, 2012	"the hospital"		"charges"	"payments for each payer"		"reported as required by the office"		Unlegislated report	
	STATUTE(S): Connecticut General Statutes §19a-649 ENACTED BILL(S): Added: 1958, S.H.B.7290 (1989); Amended: S.H.B. 7214 (1991), S.H.B. 6949 (1993), S.H.B. 7079 (1993), H.B. 6678 (2009), H.B. 5321 (2012)	Added: 1958, 1989 Amended: 1991, 1993, 1993, 2009, 2012	"Each hospital"		"the total and average charges and costs"		"of charity care and reduced cost services provided"	"report [to the office]"		Unlegislated report	
	STATUTE(S): Connecticut General Statutes §§19a-644, 19a-654 ENACTED BILL(S): Added: 1958, S.H.B.7290 (1989); Amended: S.H.B. 7214 (1991), S.H.B. 6949 (1993), S.H.B. 7079 (1993), H.B. 6678 (2009), H.B. 5321 (2012)	Added: 1958, 1989 Amended: 1991, 1993, 2009, 2012	"short-term acute care general or children's hospitals"		"discharge data […] from medical record abstracts and hospital bills"			"submit [to the] office"		Unlegislated report	

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Connecticut	STATUTE(S): Connecticut General Statutes §19a-681 ENACTED BILL(S): Added: H.B. 7030 (1995); Amended: S.B. 1145 (2005), S.B. 622 (2008), S.B. 494 (2010)	Added: 1995 Last Amended: 2005, 2008, 2010	"Each hospital"		"current price-master which shall include each charge in its detailed schedule of charges"			"shall file with the office"			
Delaware	STATUTE(S): Delaware Code §2003 ENACTED BILL(S): Added: 1989; Amended: H.B. 507 (1994), S.B. 47 (2009)	Added: 1989 Amended: 1994, 2009	"Hospitals and nursing homes"	"Charge levels [and] trends in health care charges"				"submitted by all […] to the state agency"		"state agency shall prepare and distribute or make available reports to health care purchasers, health care insurers, health care providers and the general public"	
	STATUTE(S): Delaware Code Ann. §§2004, 2006 ENACTED BILL(S): Added: 1989; Amended: H.B. 507 (1994), S.B. 235 (2008)	Added: 1989 Amended: 1994, 2009	"all hospitals [and] all nursing home"				"all hospital [and] nursing home inpatient discharges"	"submitted by all […] to the state agency"		"All compilations prepared and authorized by the state agency for release and dissemination shall be public records"	

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Florida	STATUTE(S): Florida Statutes §381.026 ENACTED BILL(S): Added: S.B. 292 (1991), H.B. 367–H (1992), S.B. 598 (1995); Amended: C.S.H.B. 475 (2001), S.B. 1324 (2001), H.B. 1629 (2004), H.B. 7073 (2006), S.B. 1488 (2008), H.B. 155 (2011), H.B. 935 (2011), H.B. 7007 (2012)	Added; 1991, 1992, 1995 Amended: 1998, 1999, 2001, 2004, 2006, 2008, 2009, 2011, 2012	"primary care provider"		"schedule of charges […] the schedule must include the prices charged to an unin-sured person"		"must include, but is not limited to, the 50 services most frequently provided"		"posted in a conspicuous place in the reception area"		
	STATUTE(S): Florida Statutes §381.026 ENACTED BILL(S): Added: S.B. 292 (1991), H.B. 367–H (1992), S.B. 598 (1995); Amended: C.S.H.B. 475 (2001), S.B. 1324 (2001), H.B. 1629 (2004), H.B. 7073 (2006), S.B. 1488 (2008), H.B. 155 (2011), H.B. 935 (2011), H.B. 7007 (2012)	Added; 1991, 1992, 1995 Amended: 1998, 1999, 2001, 2004, 2006, 2008, 2009, 2011, 2012	"health care provider or a health care facility shall"		"a reasonable estimate of charges				"furnish a person […] before the provision of a planned nonemergency medical service"		

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Florida	STATUTE(S): Florida Statutes §395.301 ENACTED BILL(S): Added: H.B. 367–H (1992), S.B. 598 (1995) Amended: S.B. 2128 (1998), H.B. 1629 (2004), H.B. 7073 (2006), S.B. 1488 (2008)	Added: 1982, 1991, 1992, 1995 Amended: 1998, 2004, 2006, 2008	"Each licensed facility not operated by the state"		"good faith estimate of reasonably anticipated charges […] The estimate may be the average charges for that diagnosis related group or the average charges for that procedure"		"any non-emergency medical services"		"upon request from the patient"		
	STATUTE(S): Florida Statutes §395.107 ENACTED BILL(S): Added: H.B. 935 (2011); Amended: H.B. 787 (2012)	Added: 2011 Amended: 2012	"urgent care center [and] affiliated facility"		"schedule of charges"		"no fewer than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures"		"publish [and] posted in a conspicuous place in the reception area"		
	STATUTE(S): Florida Statutes §408.05 ENACTED BILL(S): Added: H.B.1673 (1988); Amended: C.S.S.B. 314 (1998), H.B. 1053 (1999), S.B. 1766 (2000), S.B. 2568 (2003), H.B. 1629 (2004), H.B. 763 (2005), H.B. 7073 (2006), S.B. 1488 (2008), S.B. 1784 (2010)	Added: 1988, 1990, 1991, 1992, 1995, 1997 Amended: 1998, 1999, 2000, 2003, 2004, 2005, 2006, 2007, 2008, 2010	"health care facilities"		"undiscounted charges"		"no fewer than 150 of the most commonly performed adult and pediatric procedures"				"Publish on its website"

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Florida	STATUTE(S): Florida Statutes §408.061 ENACTED BILL(S): Added: S.B. 2390 (1992); Amended: S.B. 1914, 2006, 1784 & S.B 406 (1993), S.B. 226 (1995), S.B. 226 (1996), S.B. 430 (1997), S.B. 314 (1998), H.B. 1053 (1999), S.B. 1766 (2000), S.B. 2568 (2003), H.B. 1629 (2004), H.B. 763 (2005), H.B. 7073 (2006)	Added: 1992 Amended: 20061993, 1996, 1997, 1998, 1999, 2000, 2003, 2004, 2005, 2006	"health care facilities"		"actual charge data by diag-nostic groups"			"[to the] agency"			
	STATUTE(S): Florida Statutes §408.061 ENACTED BILL(S): Added: S.B. 2390 (1992); Amended: H.B. 7073 (2006)	Added: 1992 Amended: 2006	"health insurers"		"claims […] However […] shall not include specific pro-vider contract reimbursement information""			"[to the] agency"			
Georgia	STATUTE(S): Georgia Code §31-7-280 ENACTED BILL(S): Added: 1988; Amended: S.B. 433 (2008)	Added: 1988 Amended: 2008	"each health care provider"		"total charges and summary of charges by revenue code"			"submitted to the department"			

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Illinois	STATUTE(S): 20 Illinois Compiled Statutes §2215/4-2 (4) ENACTED BILL(S): Added: 1984; Amended: H.B. 2343 (2005), H.B. 1562 (2011), S.B. 1282 (2011), S.B. 3798 (2012)	Added: 1984 Amended: 2012	"hospitals"		"claims and encounter data"		"inpatient and outpatient claims and encounter data related to surgical and invasive procedures"	"compiled by the department"		"Publicly disclosed information must be provided in language that is easy to understand and accessible to consumers using an interactive query system"	
	STATUTE(S): Illinois Compiled Statutes §2215/4-2 (5) ENACTED BILL(S): Added: 1984; Amended: H.B. 2343 (2005); H.B. 1562 (2011); S.B. 1282 (2011); S.B. 3798 (2012)	Added: 1984 Amended: 2012	"each ambulatory surgical treatment center"		"outpatient claims and encounter data collected […] for each patient"			"collect[ed] compile[d] by the department"		"Publicly disclosed information must be provided in language that is easy to understand and accessible to consumers using an interactive query system"	
	STATUTE(S): Illinois Compiled Statutes §2215/4-2 (6) ENACTED BILL(S): Added: 1984; Amended: H.B. 2343 (2005), H.B. 1562 (2011), S.B. 1282 (2011), S.B. 3798 (2012)	Added: 1984 Amended: 2002, 2011, 2012	"Ambulatory surgical treatment centers and hospitals"		"average charges"		"at least 30 inpatient [and] 30 outpatient conditions and procedures […] demonstrate[ing] the highest degree of variation in patient charges and quality of care"	"compiled by the department"			"shall make available on its website the 'Consumer Guide to Care'"

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Illinois	STATUTE(S): Illinois Compiled Statutes §2215/4-4(a) ENACTED BILL(S): Added: 1984; Amended: H.B. 4580 (2002)	Added: 1984 Amended: 2002	"Hospitals"		"the normal charge incurred"		"any procedure or operation the prospective patient is considering"		"to prospective patients"		
	STATUTE(S): Illinois Compiled Statutes §2215/4-4(b) ENACTED BILL(S): Added: 1984; Amended: H.B. 4580 (2002)	Added: 1984 Amended: 2002	"hospitals"		"the established charges"		"including but not limited to the hospital's private room charge, semi-private room charge, charge for a room with 3 or more beds, intensive care room charges, emergency room charge, operating room charge, electrocardiogram charge, anesthesia charge, chest x-ray charge, blood sugar charge, blood chemistry charge, tissue exam charge, blood typing charge and Rh factor charge"		"to post in letters"		

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Indiana	STATUTE(S): Indiana Code §16-21-6 ENACTED BILL(S): Added: S.E.A. 24 (1993); Amended: H.E.A. 1200 (2002), S.E.A. 366 (2011)	Added: 1993 Amended: 2002, 2011	"each hospital"		"Total charge for patient's stay"			"file with the state department"	"shall provide copies of the reports […] to the public upon request"	"Annually publish a consumer guide to Indiana hospitals"	
Iowa	STATUTE(S): Iowa Code §135.165; §135.166 ENACTED BILL(S): Added: H.B. 2539 (2008); Amended: S.F. 389 (2009)	Added: 2008 Amended: 2009	"hospitals"		"quality and cost measures"		"inpatient, outpatient, and ambulatory information"	"department of public health shall […] utilize the Iowa hospital association to act as the department's intermediary in collecting, maintaining, and disseminating"			"shall be […] published on a public internet site available to the general public" (originally the task of a work force now completed and deleted from statute)
Kansas	STATUTE(S): Kansas Statutes §65-6801; §65-6805 ENACTED BILL(S): Added: S.B. 118 (1993) ; Amended: S.B. 577 (1994), S.B. 272 (2005), S.B. 397 (2012)	Effective 1993 Amended 1994, 2005, 2012	"all providers of health care services and third-party payors"		"costs"			"shall file […] with the department of health and environment"	"made available in a form […] to improve the decision-making processes"		

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Kentucky	STATUTE(S): Kentucky Revised Statute §216.2929 ENACTED BILL(S): Added: H.B. 250 (1994); Amended: S.B. 343 (1996), H.B. 132 (1998), S.B. 47 (2005), H.B. 44 (2008), H.B. 265 (2012)	Added: 1994 Amended: 1996, 1998, 2005, 2008, 2012	"every hospital and ambulatory facility, differentiated by payor if relevant, and for other provider groups"		"charges […]include the median charge"			"compiled and reported by the cabinet"		"reported by the cabinet"	"make available on its Web site […] sufficient explanation to allow consumers to draw meaningful comparisons" AND "provide linkages to organizations that publicly report comparative-charge data for Kentucky providers"
	STATUTE(S): Kentucky Revised Statutes §216.2923, §216.2929 ENACTED BILL(S): Added: H.B. 250 (1994); Amended: S.B. 343 (1996), H.B. 132 (1998), S.B. 47 (2005), H.B. 44 (2008), H.B. 265 (2012)	Added: 1994 Amended: 1996, 1998, 2005, 2008, 2012			"information that relates to the health-care financing and delivery system, information on charges for health-care services"			"the secretary shall […] collect"			

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
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Louisiana	STATUTE(S): Louisiana Revised Statutes §§40:1300.111, 112, 113, 114 ENACTED BILL(S): Added: H.B. 1462 (1997); Amended: S.B. 287 (2008)	Added: 1997 Amended: 2008	"All health care providers licensed by the state, including but not limited to hospitals, outpatient surgical facilities, and outpatient clinical facilities"		"health care cost, quality, and perfor-mance data"			"reported to the Department of Health and Hospitals"			"Internet publication of provider and health plan specific cost, quality, and performance data […] for access and use by a consumer" AND Unlegislated Louisiana Hospital Inpatient Discharge Database (LAHIDD)
Maine	STATUTE(S): Maine Revised Statutes §§ 8704, 6 ENACTED BILL(S): Added: H.P. 1307 (1996); Amended: S.P. 560 (1997), S.P. 18 (1999), H.P. 1003 (1999), S.P. 395 (2001), H.P. 1187 (2003), H.P. 942 (2005), S.P. 677 (2006), S.P. 290 (2007), H.P. 5 (2007), S.P. 578 (2012)	Added: 1996 Amended: 1997, 1999, 2001, 2003, 2005, 2006, 2007, 2012	"health care facilities, providers or payors"		"clinical, financial, quality and restructuring data"	"clinical, financial, quality and restructuring data"		"board shall develop and implement policies and procedures for the collection, processing, storage and analysis"			

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Maine	STATUTE(S): Maine Revised Statutes §8712 ENACTED BILL(S): Added: H.P. 1187 (2003); Amended: H.P. 975 (2005), H.P. 85 (2009), S.P. 529 (2009), H.P. 1088 (2010), H.P. 602 (2012)	Added: 2003 Amended: 2005, 2009, 2009, 2010, 2012	"health care facilities and practitioners"			"payments for services rendered"	"services presented must include, but not be limited to, imaging, preventative health, radiology and surgical services and other services that are predominantly elective and may be provided to a large number of patients who do not have health insurance"	"State shall collect, synthesize and publish information"	"shall make reports available to members of the public upon request"		"create a publicly accessible interactive website"
	STATUTE(S): Maine Revised Statutes §8712 ENACTED BILL(S): Added: H.P. 1187 (2003); Amended: H.P. 975 (2005), H.P. 85 (2009), S.P. 529 (2009), H.P. 1088 (2010), H.P. 602 (2012)	Added: 2003 Amended: 2005, 2009, 2009, 2010, 2012		"commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors"		"prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors"	"15 most common diagnosis-related groups and the 15 most common outpatient procedures for all hospitals in the State and the 15 most common procedures for nonhospital health care facilities"	"State shall collect, synthesize and publish information"	"shall make reports available to members of the public upon request"		"create a publicly accessible interactive website"

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Maryland	STATUTE(S): Maryland Code, Health – General §19-133 ENACTED BILL(S): Added: 1993; Amended: S.B. 221 (1999), H.B. 995 (1999), S.B. 189 (2000), S.B. 196 (2001), S.B. 786 (2001), H.B. 800 (2007)	Added: 1993 Amended: 1994, 1995, 1997, 1999, 2000, 2001, 2007	"health care practitioner or facility"	"payors and governmental agencies"	"the charge for the procedure," […]"health care costs, utilization, or resources"			"the Commission shall [collect]"		"shall publish an annual report […] Describ[ing] the variation in fees charged by health care practitioners and facilities"	
	STATUTE(S): Maryland Code, Health – General §§ 19-202, 7 ENACTED BILL(S): Added: 1982; Amended: 1984, 1997, 1999, S.B. 479 (2003), S.B. 380 (2006), H.B. 844 (2007)	Added: 1982 Amended: 1984, 1997, 1999, 2003, 2006, 2007			"Health care costs"			Creates the "Health Services Cost Review Commission [that] shall Periodically participate in or do analyses and studies of"		"Each report filed and each summary, compilation, and report required under this subtitle available for public inspection"	

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Massachusetts	STATUTE(S): Massachusetts General Laws 12C §8 (a) ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012	"institutional providers and their parent organizations and any other affiliated entities, non-institutional providers and provider organizations"		"revenues, charges, costs, prices, and utilization […]filing of a charge book, the filing of cost data and audited financial statements and the submission of merged billing and discharge data"		"medical, surgical, diagnostic and ancillary services"	"The center shall also collect and analyze"			
	STATUTE(S): Massachusetts General Laws 12C §8 (b) ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012	"any acute or non-acute hospital"		"a charge book, the filing of cost data and audited financial statements and the submission of merged billing and discharge data"					"at least annually, publish a report analyzing the comparative information to assist third-party payers and other purchasers of health services in making informed decisions"	"shall publicly report and place on its website […] relative prices and hospital inpatient and outpatient costs, including direct and indirect costs"
	STATUTE(S): Massachusetts General Laws 12C §8 (d) ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012			"relative prices"		"inpatient and outpatient"				"shall publicly report and place on its website"

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Massachusetts	STATUTE(S): Massachusetts General Laws 12C §10 ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012		"from private and public health care payers, including third-party administrators"	"relative prices for the payer's participating health care providers by provider type which shows the average relative price, the extent of variation in price, stated as a percentage, and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the average relative price"	"submit claims data […] and relative prices paid to every hospital, registered provider organization, 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, with hospital inpatient and outpatient prices listed separately by [insurance] product type"		"The center shall require the submission of data and other information"		"Except as specifically provided otherwise by the center or under this chapter, insurer data collected by the center under this section shall not be a public record"	
	STATUTE(S): Massachusetts General Laws 12C §16 ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012	"health care provider, provider organization"	"private and public health care payer"	"costs and cost trends […] price [and] price variation between health care providers, by payer and provider type"	"costs and cost trends […] and price variation between health care providers, by payer and provider type"		"The center collects"		"The center shall publish an annual report"	

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Massachusetts	STATUTE(S): Massachusetts General Laws 6A C §16K ENACTED BILL(S): Added: H.B. 4479 (2006) Amended: H.B. 5240 (2006), S.B. 2863 (2008), S.B. 2585 (2010), S.B. 2400 (2012)	Added: 2006 Amended: 2006, 2008, 2010, 2012		"health care quality and cost data"		"Cost information shall include, at a minimum, the average payment […] on behalf of insured patients"	"for obstetrical services, physician office visits, high-volume elective surgical procedures, high-volume diagnostic tests and high-volume therapeutic procedures"	"shall be collected"			"shall establish and maintain a consumer health information website […] comparing the cost and quality of health care services […] by facility and, as applicable, by clinician or physician group practice"
	STATUTE(S): Massachusetts General Laws 111C § 228 ENACTED BILL(S): Added: S.B. 2400 (2012)	Added: 2012	"a health care provider"		"disclose the […] charge"	"disclose the […] the contractually agreed upon amount paid by a carrier to a health care provider for health care services provided to an insured" AND "out-of-pocket costs"	"of the admission, procedure or service, including the amount for any facility fees required"		"upon request by a patient or prospective patient"		

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Minnesota	STATUTE(S): Minnesota Statutes §62J.82 ENACTED BILL(S): Added: H.F. 139 (2005) Amended: H.F. 1078 (2007)	Added: 2005 Amended: 2007	"hospital"		"Charge information, [including] average charge, average charge per day and median charge"		"for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures"				"The Minnesota Hospital Association shall develop a Web-based system"
	STATUTE(S): Minnesota Statutes §62J.052 ENACTED BILL(S): Added: S.F. 1204 (2005) Amended: S.F. 3480 (2006)	Added: 2005 Amended: 2006	"Each pharmacy"		"usual and customary price for a prescription drug"				"readily available at no cost to the patient"		
	STATUTE(S): Minnesota Statutes §62U.04 (Subd. 1) ENACTED BILL(S): Added: S.F. 3780 (2008) Amended: S.F. 2082 (2009), H.F. 3056 (2010), H.F. 25 (2011), S.F. 1809 (2012)	Added: 2008 Amended: 2009, 2010, 2011, 201	"providers"		"comparative information to consumers on variation"						
	STATUTE(S): Minnesota Statutes §62U.04 (Subd. 3c) ENACTED BILL(S): Added: S.F. 3780 (2008) Amended: S.F. 2082 (2009), H.F. 3056 (2010), H.F. 25 (2011), S.F. 1809 (2012)	Added: 2008 Amended: 2009, 2010, 2011, 2012	"providers"		"total cost" AND "condition-specific cost"					"public report"	

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Minnesota	STATUTE(S): Minnesota Statutes §62U.04 (Subd. 5) ENACTED BILL(S): Added: S.F. 3780 (2008) Amended: S.F. 2082 (2009), H.F. 3056 (2010), H.F. 25 (2011), S.F. 1809 (2012)	Added: 2008 Amended: 2009, 2010, 2011, 2012		"all health plan companies and third-party administrators"		"submit data on their contracted prices with health care providers"		"to a private entity designated by the commissioner of health"			
	STATUTE(S): Minnesota Statutes §62J.82 ENACTED BILL(S): Added: H.F. 139 (2005) Amended: H.F. 1078 (2007)	Added: 2005 Amended: 2007	"hospital"		"Charge information, [including] average charge, average charge per day and median charge"		"for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures"				"The Minnesota Hospital Association shall develop a Web-based system"
	STATUTE(S): Minnesota Statutes §144.698 ENACTED BILL(S): Added: S.F. 60 (1976) Amended: S.F. 109 (1977), H.F. 1966 (1984), H.F. 1759 (1989), S.F. 910 (1991), S.F. 2080 (2004), H.F. 1078 (2007)	Added: 1976 Amended: 1977, 1984, 1989, 1991, 2004, 2007	"Each hospital and each outpatient surgical center"		"cost information"			"shall file annually with the commissioner of health"		"All reports [...] shall be open to public inspection"	
	STATUTE(S): Minnesota Statutes § 144.699 ENACTED BILL(S): Added: S.F. 60 (1976) Amended: S.F. 109 (1977), H.F. 1966 (1984), S.F. 51 (1987), H.F. 1078 (2007)	Added: 1976 Amended: 1977, 1984, 1987, 2007	"hospitals, outpatient surgical centers, home care providers, and professionals"				"for procedures and services that are representative of the diagnoses and conditions for which citizens of this state seek treatment"			"The Commissioner of Health shall "disseminate available price information" AND "encourage [providers] to publish prices"	

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Minnesota	STATUTE(S): Minnesota Statutes § 144.701 ENACTED BILL(S): Added: S.F. 60 (1976) Amended: S.F. 109 (1977), H.F. 2175 (1982), H.F. 1966 (1984), H.F. 1759 (1989), S.F. 3346 (1998), H.F. 2446 (2004), S.F. 2082 (2009)	Added: 1976 Amended: 1977, 1982, 1984, 1989, 2998, 4004, 2009	"each hospital and outpatient surgical center"		"a current rate schedule"			"shall be filed with the commissioner of health"			
	STATUTE(S): Minnesota Statutes §144.0506 ENACTED BILL(S): S.F. 367 (2006)	Added: 2006	"health care provider"		"charges"		"for common procedures"				"agency Web sites, including minnesota-healthinfo.com"
Missouri	STATUTE(S): Missouri Revised Statutes §192.665, §192.667 ENACTED BILL(S): Added: H.B. 1574 (1992) Amended: S.B. 721 (1992), S.B. 796 (1992), S.B. 1279 (2004)	Added: 1992 Amended: 1992, 2004	"All health care providers [includes hospitals and ambulatory surgical centers]"		"charge data"			"provide to the department"		"The report shall be made available to the public for a reasonable charge" AND "The Hospital Industry Data Institute shall publish a report" AND "publish information including at least an annual consumer guide"	

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Montana	UNLEGISLATED		"facility specific information"		"charges"		"inpatient and outpatient"				Unlegislated Montana PricePoint developed by Montana Hospital Association and An Association of Montana Health Care Providers
Nebraska	STATUTE(S): Nebraska Statutes §71-2075 ENACTED BILL(S): Added: 1985; Amended: L.B. 1210 (1994)	Added: 1985 Amended: 1994	"each hospital […] and ambulatory surgical centers"		"average charges"				"Upon the written request of a prospective patient" AND "shall provide notice to the public that such hospital or center will provide an estimate of charges"		
Nevada	STATUTE(S): Nevada Revised Statutes §§ 439A.220, 439A.240, 439A.260, 439A.270 ENACTED BILL(S): Added: A.B. 146 (2007); Amended: S.B. 319 (2009), A.B. 160 (2011), S.B. 264 (2011), S.B. 338 (2011), S.B. 340 (2011)	Added: 2007 Amended: 2009, 2011	"each hospital" AND "each surgical center for ambulatory patients"		"average billed charges" AND "charges imposed"		"reported by diagnosis-related groups for inpatients and for the 50 medical treatments for outpatients" AND "for […] potentially preventable readmissions"	"The Department shall establish and maintain a program that […] must include the collection	"Upon request, make the information that is contained on the Internet website available in printed form"	"shall make a summary of the information available to Consumers of health care [and] the general public"	"shall establish and maintain an Internet website"

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Nevada	STATUTE(S): Nevada Revised Statutes §449.490 ENACTED BILL(S): Added: 1975; Amended: 1985, 1987, A.B. 342 (2005), A.B. 146 (2007), A.B. 160 (2011)	Added: 1975 Amended: 1985, 1987, 2005, 2007, 2011	"each hospital"		"chargemaster"			"made available to the Department"	"information that may relate to individual citizens may be released"		
New Hampshire	STATUTE(S): New Hampshire Revised Statutes §§420-G:11, 420-G:11-a ENACTED BILL(S): Added: H.B. 670 (2003) Amended: S.B. 74 (2005)	Added: 2003 Amended: 2005		"All health carriers"	"encrypted claims data [and] Health Employer Data and Information Set (HEDIS) data	"encrypted claims data [and] Health Employer Data and Information Set (HEDIS) data		"to the department"			"develop a comprehensive health care information system" (NHCHIS) AND "shall be available as a resource for insurers, employers, providers, purchasers of health care, […] to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices"
	STATUTE(S): New Hampshire Revised Statutes §126:25 ENACTED BILL(S): Added: 1985 Amended: S.B. 197 (2009), H.B. 544 (2009), H.B. 629 (2011)	Effective: 1985 Amended: 2009, 2011	"Acute care hospitals, specialty hospitals, nursing homes"		"charge by discharge data […] average patient day charge data"			"shall file health care data as required by the commissioner"			

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New Jersey	STATUTE(S): New Jersey Statutes §26:2H-5, §26:2H-18.55 ENACTED BILL(S): Added: 1971 and Assembly 2100 (1992); Amended: Assembly 2616 (1995), Assembly 1532 (1996), Senate 1181 (1998), Senate 539 (2006), Senate 1796 (2008)	Added: 1971, 1992 Amended: 1995, 1996, 1998, 2008	"hospital"	"costs" AND "charges for health care services"	"schedules of rates, payments, reimbursement"			"Reported to the department" AND "use of centralized data storage and transmission technology"		"reports to provide assistance to consumers of health care in this State in making prudent health care choices"	Unlegislated website
New Mexico	STATUTE(S): New Mexico Statutes §§ 24-14A-3, 24-14A-34, 24-14A-37 ENACTED BILL(S): Added: 1989; Amended: S.B. 556 (1994), H.B. 1008 (2005), S.B. 786 (2005), H.B. 293 (2009), H.B. 18 (2012)	Added: 1989 Amended: 1994, 2005, 2012	"all data sources"		"collect health data sufficient for consumers to be able to evaluate health care services, plans, providers and payers and to make informed decisions regarding quality, cost and outcome of care across the spectrum of health care services, providers and payers"			"serve as a health information clearinghouse, including facilitating private and public collaborative, coordinated data collection"	"Any person may obtain any aggregate data"	"a report in printed format that provides information of use to the general public shall be produced annually"	
New York	STATUTE(S): New York Public Health Law §2816 ENACTED BILL(S): Added: A. 1644 (2001), Amended: A. 4122–C (2005), S. 2809-D (2011), S. 2812-C (2011)	Added: 2001 Amended: 2005, 2011	"hospitals [and] all ambulatory facilities" AND "emergency departments" AND "outpatient clinic[s]"		"patient and other data element"		"Top 50 diagnostic categories" AND "Top 50 surgical procedures"			"the publication and release of data reported" (SPARCS)	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
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North Carolina	STATUTE(S): North Carolina General Statutes §131E-214.4 ENACTED BILL(S): Added: S.B. 345 (1995); Amended: S.B. 352 (1997)	Added: 1995 Amended: 1997			"charges"		"35 most frequently reported charges"	"The center shall require the submission of data and other information"	"makes medical care data available to interested persons, including medical care providers, third party payors, medical care consumers, and health care planners […] compile reports from the patient data and make the reports available upon request to interested persons at a reasonable charge"		
North Dakota	STATUTE(S): North Dakota Century Code §§23-01.1-02.1 ENACTED BILL(S): Added: S.B. 2589 (1991)	Added: 1991	"each licensed physician practicing medicine"	"Insurers, nonprofit health service corporations, health maintenance organizations, and state agencies"	"average fees charged"			"health care data committee shall create a data collection"		"shall prepare a report which must […] for consumers to use in comparing"	

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North Dakota	STATUTE(S): North Dakota Century Code §§23-01.1-02 ENACTED BILL(S): Added: S.B. 2589 (1991); Amended: H.B. 1058 (1995), H.B. 1065 (2003)	Added: 1991 Amended: 1995, 2003	"each nonfederal acute care hospital in this state""		"average aggregate charges by diagnosis […] and the average charges by source of payment"		"twenty-five most common diagnoses"	"the health care data committee may collect, store, analyze, and provide"		"Prepare an annual report comparing the cost of hospitalization by diagnosis […] Establish procedures that assure public availability of the information required to make informed health care purchasing decisions"	
Ohio	STATUTE(S): Ohio Revised Code §3727.42 ENACTED BILL(S): Added: H.B. 197 (2006); Amended: H.B. 487 (2012)	Added: 2006 Amended: 2012	"Every hospital"		"a price information list […] including (1) The usual and customary room and board charges; (2) Rates charged for nursing care, if the hospital charges separately for nursing care […] (3) The usual and customary charges, stated separately for inpatients and outpatients if different charges are imposed"		"Room and board […] selected number of x-ray, laboratory, emergency room, operating room, delivery room, physical therapy, occupational therapy and respiratory therapy services"		"available for inspection by the public" AND "At the time of admission, or as soon as practical thereafter, inform each patient of the availability of the list and on request provide the patient with a free copy of the list" AND "On request, provide a paper copy of the list to any person"		"Make the list available free of charge on the hospital's internet web site" AND Hospital Association's site

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Ohio	STATUTE(S): Ohio Revised Code §3727.34, §3727.39 ENACTED BILL(S): Added: H.B. 197 (2006)	Added: 2006	"each hospital"		"The mean, median, and range of total hospital charges"		"pertaining to inpatient services […] of the sixty diagnosis related groups […]most frequently treated" AND "pertaining to outpatient services […] of the sixty categories […] most frequently provided"	"submit to the director of health"	"On request, the hospital shall make copies available"		"available on an internet web site"
Oklahoma	STATUTE(S): Oklahoma Statutes §1-119; §1- 121 ENACTED BILL(S): Added: H.B. 2379 (1992); Amended: H.B. 1573 (1993), H.B. 2570 (1994), H.B. 2501 (1996), H.B. 2868 (1998), S.B. 1585 (2000)	Added: 1992 Amended 1993, 1994, 1996, 1998, 2000	"information providers"		"reimburse-ment, costs of operation, […] rates, charges"			"To the Division of Health Care Information within the State Department of Health"			
Oregon	ENACTED BILL(S): Added: S.B. 329 (2007)	Added: 2007	"medical and dental providers"	"health plans"	AND "informa-tion about the cost"			"to the department"		"provides enrollees"	

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Oregon	STATUTE(S): Oregon Revised Statutes §442.405; §442.430; §442.460 ENACTED BILL(S): Added: 1985, Amended: S.B. 1079 (1995), H.B. 2894 (1997), H.B. 2146 (1999)	Added: 1985 Amended 1995, 1997, 1999	"health care facilities"	"insurers or other third-party payers or employers or other purchasers of health care"	"costs of health care" AND "advance disclosure of the estimated out-of-pocket costs of a service or procedure"			"Requires the office to conduct or cause to have conducted such analyses and studies"		"file for public disclosure reports that will enable both private and public purchasers of services from such facilities to make informed decisions"	Unlegislated website
Pennsylvania	STATUTE(S): Pennsylvania Unconsolidated Statutes §449.6 ENACTED BILL(S): Added: 1986; Amended: S.B. 1052 (1993), S.B. 387 (2003), S.B. 89 (2009)	Added: 1986 Amended: 1993, 2003, 2009	"Hospitals, ambulatory services facilities, and physicians."		"Total charges" AND "charges"	"actual payments to each physician or professional rendering service"	"including, but not limited to, room and board, radiology, laboratory, operating room, drugs, medical supplies and other goods and services" AND "of each physician or professional rendering service relating to an incident of hospitalization or treatment in an ambulatory service facility"	"the council shall be required to collect"		"Make available and provide comparisons"	
	STATUTE(S): Pennsylvania Unconsolidated Statutes §449.7 ENACTED BILL(S): Added: 1986; Amended: S.B. 1052 (1993), S.B. 387 (2003), S.B. 89 (2009)	Added: 1986 Amended: 1993, 2003, 2009	"for every provider of both inpatient and outpatient services"		"cost"	"payment"				"prepare and issue reports"	

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Rhode Island	STATUTE(S): Rhode Island General Laws §§23-17.17-10 ENACTED BILL(S): Added: 1956; Amended: S 2481B (2008), H 7465A (2008)	Added: 1956 Amended: 2008	"health care providers, health care facilities"	"Insurers and governmental agencies"	"health care costs, prices"	"health insurance claims"	"health care facility services"	"The director shall establish and maintain a unified health care quality and value database"		"Provide information to consumers and purchasers of health care"	
South Carolina	STATUTE(S): South Carolina Code §44-6-170 ENACTED BILL(S): Added: 1985; Amended: 1989, S.B. 474 (1991), S.B. 507 (1993), H.B. 3546 (1993), S.B. 691 (1995)	Added: 1985 Amended: 1993, 1995	"All general acute care hospitals and specialized hospitals including, but not limited to, psychiatric hospitals, alcohol and substance abuse hospitals, and rehabilitation hospitals"	"or insurer"	"financial information" AND "charges"		"of inpatient and outpatient information"	"reported to the office"		"appropriate dissemination of health care-related data reports"	
South Dakota	STATUTE(S): South Dakota Codified Laws §34-12E-8 ENACTED BILL(S): Added: H.B. 1384 (1994)	Added: 1994	"health care provider or facility"		"All fees and charges"				"Upon request of patient"		
	STATUTE(S): South Dakota Codified Laws §§34-12E-11, 11.1 ENACTED BILL(S): Added: S.B. 169 (2005), SB 182 (2008)	Added: 2005, 2008	"Any hospital"		"the charge information"		"All Patient Refined Diagnosis-Related Groups for which that hospital had at least ten cases"	"shall report annually to the South Dakota Association of Health Care Organizations"			"develop a web-based system, available to the public at no cost, for reporting the charge information of hospitals"

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Tennessee	STATUTE(S): Tennessee Code §68-1-108, §68- 1- 119 ENACTED BILL(S): Added: 1985, S.B. 2407 (2002); Amended: S.B. 63 (1994), H.B. 3449 (2004), H.B. 2827 (2006), H.B. 596 (2011), S.B. 3011 (2012), S.B. 2416 (2012)	Added: 1985, 2002 Amended: 1994, 2004, 2006, 2011, 2012	"Each licensed hospital" AND "Each licensed ambulatory surgical treatment center (ASTC) and each licensed outpatient diagnostic center (ODC)"		"all claims data"		"on every inpatient and outpatient discharge"	"to the commissioner of health [who] shall promptly make the data available for review and copying by the Tennessee hospital association (THA)"		"shall prescribe conditions under which the processed and verified data are available to the public"	
Texas	STATUTE(S): Vernon's Texas Statute and Codes Texas Health & Safety Code §§108.006, 9, 11, 12 ENACTED BILL(S): Added: H.B. 1048 (1995); Amended: S.B. 802 (1997), H.B. 1513 (1999), S.B. 872 (2005)	Added: 1994 Amended: 1997, 1999, 2005	"hospitals, ambulatory surgical centers, and free-standing radiology centers"		"collect health care charges"		"prioritize data collection efforts on inpatient and outpatient surgical and radiological procedures"	"The council shall develop a statewide health care data collection system to"	"provide public use data and data collected […] to those requesting it"	"make reports to the legislature, the governor, and the public on the charges and rate of change in the charges for health care services"	"shall provide a means for computer-to-computer access" AND Unlegislated Texas Pricepoint
	STATUTE(S): Vernon's Texas Statute and Codes Health & Safety Code § 324.051 AND Occupations Code § 154.002 ENACTED BILL(S): Added: S.B. 1731 (2007) Amended: H.B. 2256 (2009)	Added: 2007 Amended: 2009	"the facility" AND "physician"		"information in the guide concerning facility pricing practices and the correlation between a facility's average charge" AND "the actual, billed charge"		"an inpatient admission or outpatient surgical procedure"	"to submit to the Department"		"shall make available on the department's Internet website a consumer guide to health care"	

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Texas	STATUTE(S): Vernon's Texas Statute and Codes Health & Safety Code §324.101 AND Occupations Code §101.352 ENACTED BILL(S): Added: S.B. 1731 (2007); Amended: H.B. 2256 (2009)	Added: 2007 Amended: 2009	"Facility" and "physician"		"an estimate of the facility's [or physician's] charges"		"for any elective inpatient admission or nonemergency outpatient surgical procedure or other service"		"on request and before the scheduling of the admission or procedure or service"		
Utah	STATUTE(S): Utah Health Code §§26-33a-104, 106.1, 106.5 ENACTED BILL(S): Added: S.B. 235 (1990), S.B. 171 (1996), H.B. 9 (2007); Amended: S.B. 171 (1996), H.B. 208 (2001), S.B. 132 (2005), H.B. 9 (2007), H.B. 63 (2008), H.B. 294 (2010), H.B. 213 (2011), H.B. 144 (2012)	Added: 1990, 1996, 2007 Amended: 1996, 2001, 2005, 2007, 2008, 2010, 2011, 2012	"health care providers"		"measure-ments of cost" AND "rate and price increases"			"purpose of the committee is to direct a statewide effort to col-lect, analyze, and distribute health care data"		"assist the Legislature and the public with awareness of, and the promotion of, transparency in the health care market by reporting"	
	STATUTE(S): Utah Health Code §§26-3-2, 4 ENACTED BILL(S): Added: 1981	Added: 1981			"health care costs and financing"			the depart-ment may […] collect and maintain health data		"publish, make available, and disseminate such statistics on as wide a basis as practi-cable"	

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Utah	STATUTE(S): Utah Health Code §26-21-27 ENACTED BILL(S): H.B. 294 (2010)	Added: 2010	"a health care facility"		"a list of prices charged"		"in-patient procedures; (b) out-patient procedures; (c) the 50 most commonly prescribed drugs in the facility; (d) imaging services; and (e) implants"	submitted to "the department"			"available for the consumer" Utah Pricepoint
Vermont	STATUTE(S): Vermont Statutes 18 §9405b ENACTED BILL(S): Added: H. 128 (2003) Amended: H. 516 (2005), H. 227 (2006), H. 881 (2006), H. 380 (2007), H. 202 (2011)	Added: 2003 Amended: 2005, 2006, 2007, 2011	"hospitals and other groups of health care professionals"		"measures that provide valid, reliable, useful, and efficient information for payers and the public for the comparison of charges"		"for higher volume health care services"	"The commissioner[…] shall [establish] a standard format for community reports"		"The commissioner shall publish the reports on a public website and shall develop and include a format for comparisons of hospitals within the same categories of quality and financial indicators"	
	STATUTE(S): Vermont Statutes 18 §9410 ENACTED BILL(S): Added: H.B. 733 (1992), Amended: S. 345 (1996), H. 516 (2005), H. 678 (2006), H. 861 (2006), H. 229 (2007), S. 115 (2007), S. 42 (2009), H. 444 (2009), H. 202 (2011)	Added: 1992 Amended: 1996, 2005, 2006, 2007, 2009, 2010, 2011	"health care providers, health care facilities"	"All health insurers"	"any other information relating to health care costs, prices"	"health insurance claim"		"required to be filed by the commissioner"			"a consumer health care price and quality information system designed to make available to consumers transparent health care price information"

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Virginia	STATUTE(S): Virginia Code §32.1-276.5:1 ENACTED BILL(S): Added: H.B. 603 (2008) Amended: S.B. 396 (2008)	Added: 2008 Amended: 2008	"for all providers and provider types, to include hospitals, outpatient or ambulatory surgery centers and physician offices"	"carriers offering private group health insurance policies"		"the average reimbursement paid for a specific service" AND "the same services provided for reimbursement by fee-for-service Medicare and Medicaid"	"a minimum of 25 most frequently reported health care services which may include inpatient and outpatient diagnostic services, surgical services or the treatment of certain conditions or diseases"	"managed by the Commissioner"			

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Virginia	STATUTE(S): Virginia Code §32.1-276.4, 32.1-276.5:1, 32.1-276.6 ENACTED BILL(S): Added: H.B. 1307 (1996), H.B. 603 (2008); Amended: S.B. 396 (2008), H.B. 710 (2010), H.B. 343 (2012), S.B. 135 (2012)	Added: 1996, 2008 Amended: 2008, 2010, 2012	"for all providers and provider types, to include hospitals, outpatient or ambulatory surgery centers and physician offices"	"carriers offering private group health insurance policies"	"price information" AND "total charges"	"the aggregate information so that readers will be able to determine the average amount of reimbursement paid"		"The Commissioner shall negotiate and enter into contracts or agreements with a nonprofit organization for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to this chapter; for the operation of the All-Payer Claims Database"		"public survey reports"	"shall be made available to the public through an Internet Website operated by the contracting organization" AND "shall take steps to increase public awareness of the data and information available through the nonprofit organization's website and how consumers can use the data and information when making decisions about health care providers and services"

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Washington	STATUTE(S): Revised Code of Washington §70.41.250 ENACTED BILL(S): Added: S.S.S.B. 5304 (1993)	Added: 1993	"the hospital"		"charges"		"all health care services ordered"		"made available to any physician and/or other health care provider ordering care in hospital inpatient/outpatient services. The physician and/or other health care provider may inform the patient of these charges and may specifically review them"		Unlegislated Washington Hospital
West Virginia	STATUTE(S): West Virginia Codes §§16-29B-1, §16-29B-18, §16-29B-21, §16-29B-25 ENACTED BILL(S): Added: 1983; Amended: H.B. 2194 (1991), S.B. 458 (1997)	Added: 1983 Amended: 1991, 1997	"health care providers"		"health care costs"			"an entity of state government must be given authority […] to gather and disseminate health care information"		"to analyze and report on changes in the health care delivery system" AND "publish and disseminate any information which would be useful to members of the general public in making informed choices about health care providers"	

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West Virginia	STATUTE(S): West Virginia Codes §16-5F-2 ENACTED BILL(S): Added: 1979; Amended: H.B. 2194 (1991)	Added: 1979 Amended: 1991, 1996	"Every covered facility and related organization"		"A complete schedule of such covered facility's or related organization's then current rates" AND "A statement of all charges"			"file with the board"	"Copies of such reports shall be made available to the public upon request"		
Wisconsin	STATUTE(S): Wisconsin Statutes §153.05 (1)(a) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"health care providers other than hospitals and ambulatory surgery centers"		"health care information"					"disseminate […] in language that is understandable to laypersons.	
	STATUTE(S): Wisconsin Statutes §153.05 (1)(c) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005		"insurers" and administrators"	"health care claims information with respect to the cost, quality, and effectiveness"			"the data organization under contract"			"shall analyze and publicly report […] in language that is understandable by lay persons"
	STATUTE(S): Wisconsin Statutes §153.05 (2m)(a) & (8)(b) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"hospitals and ambulatory surgery centers"		"claims information and other health care information"			"a [contracted] entity"			
	STATUTE(S): Wisconsin Statutes §153.05 (8)(a) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"from health care providers, other than hospitals and ambulatory surgery centers"		"claims information and other health care information"			"the department shall collect"		"disseminate, in language that is understandable to laypersons"	

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
			Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
STATE	**LAWS**	**YEAR**									
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Wisconsin	STATUTE(S): Wisconsin Statutes §153.05 (8)(c) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005		"insurers and administrators"	"health care claims information"			"the data organization"		publicly report, in language that is understandable to laypersons	
	STATUTE(S): Wisconsin Statutes §153.08 ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"hospital"		"rates or charge [change]"					"published a class 1 notice […] in a newspaper"	
	STATUTE(S): Wisconsin Statutes §153.22 ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"hospitals and ambulatory surgery centers"		"utilization, charge, and quality data on patients"					"annual report"	
	STATUTE(S): Wisconsin Statutes §153.45 ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"health care provider that is not a hospital or ambulatory surgery center"		"Charges assessed with respect to the procedure code"					"public use data files"	
	STATUTE(S): Wisconsin Statutes §146.903 (3)(a) ENACTED BILL(S): Added: AB 907 §11-31 (2005)	Added: 2005	"health care provider or the health care provider's designee"		"the median billed charge, assuming no medical complications"		"for a health care service, diagnostic test, or procedure"		"upon request by and at no cost to a health care consumer"		

STATE LAWS ON HEALTH CARE PRICE TRANSPARENCY AND DISCLOSURE											
			SCOPE OF HEALTH CARE PROVIDERS		SCOPE OF PRICE		SCOPE OF SERVICES	LEVEL OF TRANSPARENCY			
STATE	LAWS	YEAR	Scope of Health Care Providers	Insurers are required to report? (Not factored in grading)	Charge	Paid Amount	Scope of Services	Reported to the State	Available upon request	Available in Report	Available on Website
Description	Relevant statute(s) with a hyperlink to the text and all relevant enacted bills with available hyperlinks	If available, date of enactment	May legislate hospitals, surgical centers, or all providers including individual physicians	May legislate health plans, insurers, or carriers to report to the state	Includes average annual charges, charge estimates, actual charges	Demonstrates accepted reimbursement rates from different payers	May legislate only most common procedures, only outpatient services, or all billable services	Price information is reported to the state	Price information is available to an individual upon request	Price information is available in a publicly available report	Price information is available on a website
Wisconsin	STATUTE(S): Wisconsin Statutes §146.903 (3)(b) ENACTED BILL(S): Added: AB 614 §5 (2009)	Added: 2009	"a health care provider" EXCEPT "A health care provider that is an association of 3 or fewer individual health care providers"		"charge information" AND "1. The median billed charge; 2. If the health care provider is certified as a provider of Medicare, the Medicare payment to the provider; 3. The average allowable payment from private, 3rd–party payers"		"25 presenting conditions identified"		"upon request by and at no cost to a health care consumer, provide the consumer a copy of the document"		"may make the information available by attaching it to the document or by including the address of an Internet site where the information is posted" Wisconsin Price Point
	STATUTE(S): Wisconsin Statutes §146.903 (4)(a) ENACTED BILL(S): Added: AB 614 §5 (2009)	Added: 2009	"Each hospital"		"charge information" AND "1. The median billed charge; 2. The average allowable payment under Medicare; 3. The average allowable payment from private, 3rd–party payers"		"for inpatient care for each of the 75 diagnosis-related groups […] and for each of the 75 outpatient surgical procedures identified"		"A hospital shall, upon request by and at no cost to a health care consumer, provide the consumer a copy of the document"		"may make the information available by attaching it to the document or by including the address of an Internet site where the information is posted" Wisconsin Price Point
Wyoming	UNLEGISLATED: Developed by Wyoming Hospital Association with data from Hospital Industry Data Institute.		"all Wyoming hospitals"		"charge information"						Wyoming Price Point

STATEMENT BY CPR PURCHASERS ON PRICE AND QUALITY TRANSPARENCY IN HEALTH CARE

Information about the price and quality of health care services should be broadly available to those who use and pay for care

1. **Consumers must have access to meaningful, comprehensive information about the price and quality of services to make informed health care decisions.**
   - Consumers are being asked to pay more for their health care as costs rise and insurance benefits change; they have the right to know the price and quality of their health care choices.
   - Such information should be readily available and accessible in a comprehensive format that is relevant and user-friendly, including:
     - ✓ Integrated price, quality (especially outcomes data), and patient experience information for specific services that is customized to the consumer's benefit design (e.g., real-time deducible, coinsurance, and co-pay information, etc.), by illustrating the total cost of care and the amount for which the consumer is responsible.
     - ✓ Provider background, including education and medical training, Maintenance of Certification, services offered, access hours, location and online appointment scheduling; and
     - ✓ An easy-to-use and convenient platform or portal including web and mobile applications, paired with support from physicians, nurses, coaches or other trained customer service representatives to help patients use the tools to maximize their health.

2. **Providers and health plans must make such information available.**
   - Health plans have made strides and should continue to innovate with the tools they have created to share quality and price information with consumers.
   - Some providers continue to resist releasing price and quality information. To develop comprehensive transparency tools, providers must make such data available, and provide it at a level which is meaningful to consumers (e.g. at the individual hospital or physician level rather than at a health system level).
   - Many health plans have agreed that self-insured purchasers should be able to use their own claims data, including price information, as needed, though some prohibit purchasers from giving it to a third-party vendor to develop consumer transparency tools or to assist with interpretation. Health plans must eliminate these restrictions to maximize the options for transparency tools in the marketplace.

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- CPR Purchasers expect providers to remove any restrictions on health plans from making price and quality information available for use in transparency tools.
- CPR Purchasers expect health plans to allow self-insured customers full use of their own claims data including giving it to a third-party vendor to develop transparency tools.

3. **Self-insured purchasers have the right to use their claims data to develop benefit designs and tools that meet their needs.**
   - Self-insured purchasers have an interest in sharing price and quality information with their consumers to encourage them to use high-quality, cost-effective care, which may help to drive down health care spending and health care prices by encouraging providers to compete on quality and affordability.
   - Access to the most complete price and quality information also helps purchasers develop innovative and integrated benefit design and payment reform strategies.
   - Self-insured purchasers should seek health plan partners with tools that meet their needs or that allow them to use their own claims data in a manner that meets their needs, such as having the flexibility to contract with other vendors to analyze and display their data.

4. **Current anti-trust laws should be adhered to and enforced to ensure that providers and health plans do not use price information in an anti-competitive manner.**
   - There could be unintended negative consequences to greater transparency on price and quality information, such as providers using it to raise their prices. To address this, appropriate parties must monitor such transparency with suitable oversight mechanisms.
   - Price and quality information released for use by consumers can be presented in such a way that targets it to consumers' expected share of the costs due to their specific health plan benefit design.