

**\*\*\*This language is based on the laws passed in Texas (Texas SB 1137 – enacted in 2021) and Colorado (Colorado HB 1285 – enacted earlier this year) which appear on the preceding pages of this binder. Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer, has expressed interest in introducing similar language next year at NCOIL for the development of an NCOIL Hospital Price Transparency Model Act\*\*\***

## **HOSPITAL PRICE TRANSPARENCY ACT**

### **Section 1: Short Title**

This Act shall be known and may be cited as the Hospital Price Transparency Act.

### **Section 2: Purpose**

The purpose of this Act is to require healthcare facilities to disclose prices for certain items and services provided by certain medical facilities; provide administrative penalties; prohibit collective action of debt for non-compliant facilities.

### **Section 3: Healthcare Facilities Required to Disclose Certain Prices to Patients**

Be it enacted by the Legislature of the State of [insert state]:

Section 1. [Insert appropriate section of state's Health and Safety Code] amended by adding [Insert name of new chapter] to read as follows:

CHAPTER [insert chapter number here]. DISCLOSURE OF PRICES

Sec. [insert chapter number here].001. DEFINITIONS.

In this chapter:

- (1) "Ancillary service" means a facility item or service that a facility customarily provides as part of a shoppable service.
- (2) "Chargemaster" means the list of all facility items or services maintained by a facility for which the facility has established a charge.
- (3) "[insert relevant state health agency acronym, if any]" means the [insert relevant state health agency].
- (4) "De-identified maximum negotiated charge" means the highest charge that a facility has negotiated with all third party payors for a facility item or service.
- (5) "De-identified minimum negotiated charge" means the lowest charge that a facility has negotiated with all third party payors for a facility item or service.
- (6) "Discounted cash price" means the charge that applies to an individual who pays cash, or a cash equivalent, for a facility item or service.
- (7) "Facility" means a hospital licensed under [insert appropriate state law].

(8) "Facility items or services" means all items and services, including individual items and services and service packages, that may be provided by a facility to a patient in connection with an inpatient admission or an outpatient department visit, as applicable, for which the facility has established a standard charge, including:

- (A) supplies and procedures;
- (B) room and board;
- (C) use of the facility and other areas, the charges for which are generally referred to as facility fees;
- (D) services of physicians and non-physician practitioners, employed by the facility, the charges for which are generally referred to as professional charges; and
- (E) any other item or service for which a facility has established a standard charge.

(9) "Gross charge" means the charge for a facility item or service that is reflected on a facility's chargemaster, absent any discounts.

(10) "Machine-readable format" means a digital representation of information in a file that can be imported or read into a computer system for further processing. The term includes .XML, .JSON, and .CSV formats.

(11) "Payor-specific negotiated charge" means the charge that a facility has negotiated with a third party payor for a facility item or service.

(12) "Service package" means an aggregation of individual facility items or services into a single service with a single charge.

(13) "Shoppable service" means a service that may be scheduled by a health care consumer in advance.

(14) "Standard charge" means the regular rate established by the facility for a facility item or service provided to a specific group of paying patients. The term includes all of the following, as defined under this section:

- (A) the gross charge;
- (B) the payor-specific negotiated charge;
- (C) the de-identified minimum negotiated charge;
- (D) the de-identified maximum negotiated charge; and
- (E) the discounted cash price.

(15) "Third party payor" means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a facility item or service.

Sec. [insert chapter number here].002. PUBLIC AVAILABILITY OF PRICE INFORMATION REQUIRED.

Notwithstanding any other law, a facility must make public:

(1) a digital file in a machine-readable format that contains a list of all standard charges for all facility items or services as described by Section [insert chapter number here].003; and

(2) a consumer-friendly list of standard charges for a limited set of shoppable services as provided in Section [insert chapter number here].004.

Sec. [insert chapter number here].003. LIST OF STANDARD CHARGES REQUIRED.

(a) A facility must:

(1) maintain a list of all standard charges for all facility items or services in accordance with this section; and

(2) ensure the list required under Subdivision (1) is available at all times to the public, including by posting the list electronically in the manner provided by this section.

(b) The standard charges contained in the list required to be maintained by a facility under Subsection(a) must reflect the standard charges applicable to that location of the facility, regardless of whether the facility operates in more than one location or operates under the same license as another facility.

(c) The list required under Subsection (a) must include the following items, as applicable:

(1) a description of each facility item or service provided by the facility;

(2) the following charges for each individual facility item or service when provided in either an inpatient setting or an outpatient department setting, as applicable:

(A) the gross charge;

(B) the de-identified minimum negotiated charge;

(C) the de-identified maximum negotiated charge;

(D) the discounted cash price; and

(E) the payor-specific negotiated charge, listed by the name of the third party payor and plan associated with the charge and displayed in a

manner that clearly associates the charge with each third party payor and plan; and

(3) any code used by the facility for purposes of accounting or billing for the facility item or service, including the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG) code, the National Drug Code (NDC), or other common identifier.

(d) The information contained in the list required under Subsection (a) must be published in a single digital file that is in a machine-readable format.

(e) The list required under Subsection (a) must be displayed in a prominent location on the home page of the facility's publicly accessible Internet website or accessible by selecting a dedicated link that is prominently displayed on the home page of the facility's publicly accessible Internet website. If the facility operates multiple locations and maintains a single Internet website, the list required under Subsection (a) must be posted for each location the facility operates in a manner that clearly associates the list with the applicable location of the facility.

(f) The list required under Subsection (a) must:

(1) be available:

(A) free of charge;

(B) without having to establish a user account or password;

(C) without having to submit personal identifying information; and

(D) without having to overcome any other impediment, including entering a code to access the list;

(2) be accessible to a common commercial operator of an Internet search engine to the extent necessary for the search engine to index the list and display the list as a result in response to a search query of a user of the search engine;

(3) be formatted in a manner prescribed by the [insert relevant state health agency];

(4) be digitally searchable; and

(5) use the following naming convention specified by the Centers for Medicare and Medicaid Services, specifically:

<ein>\_<facility-name>\_standardcharges.[jsonxmlcsv]

(g) In prescribing the format of the list under Subsection (f)(3), the [insert relevant state health agency] must:

(1) develop a template that each facility must use in formatting the list; and

(2) in developing the template under Subdivision (1):

(A) consider any applicable federal guidelines for formatting similar lists required by federal law or rule and ensure that the design of the template enables health care researchers to compare the charges contained in the lists maintained by each facility; and

(B) design the template to be substantially similar to the template used by the Centers for Medicare and Medicaid Services for purposes similar to those of this chapter, if the [insert relevant state health agency] determines that designing the template in that manner serves the purposes of Paragraph (A) and that the [insert relevant state health agency] benefits from developing and requiring that substantially similar design.

(h) The facility must update the list required under Subsection (a) at least once each year. The facility must clearly indicate the date on which the list was most recently updated, either on the list or in a manner that is clearly associated with the list.

Sec. [insert chapter number here].004. CONSUMER-FRIENDLY LIST OF SHOPPABLE SERVICES.

(a) Except as provided by Subsection (c), a facility must maintain and make publicly available a list of the standard charges described by Sections [insert chapter number here].003(c)(2)(B), (C), (D), and (E) for each of at least 300 shoppable services provided by the facility. The facility may select the shoppable services to be included in the list, except that the list must include:

(1) the 70 services specified as shoppable services by the Centers for Medicare and Medicaid Services; or

(2) if the facility does not provide all of the shoppable services described by Subdivision (1), as many of those shoppable services the facility does provide.

(b) In selecting a shoppable service for purposes of inclusion in the list required under Subsection (a), a facility must:

(1) consider how frequently the facility provides the service and the facility's billing rate for that service; and

(2) prioritize the selection of services that are among the services most frequently provided by the facility.

(c) If a facility does not provide 300 shoppable services, the facility must maintain a list of the total number of shoppable services that the facility provides in a manner that otherwise complies with the requirements of Subsection (a).

(d) The list required under Subsection (a) or (c), as applicable, must:

(1) include:

(A) a plain-language description of each shoppable service included on the list;

(B) the payor-specific negotiated charge that applies to each shoppable service included on the list and any ancillary service, listed by the name of the third party payor and plan associated with the charge and displayed in a manner that clearly associates the charge with the third party payor and plan;

(C) the discounted cash price that applies to each shoppable service included on the list and any ancillary service or, if the facility does not offer a discounted cash price for one or more of the shoppable or ancillary services on the list, the gross charge for the shoppable service or ancillary service, as applicable;

(D) the de-identified minimum negotiated charge that applies to each shoppable service included on the list and any ancillary service;

(E) the de-identified maximum negotiated charge that applies to each shoppable service included on the list and any ancillary service; and

(F) any code used by the facility for purposes of accounting or billing for each shoppable service included on the list and any ancillary service, including the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG) code, the National Drug Code (NDC), or other common identifier; and

(2) if applicable:

(A) state each location at which the facility provides the shoppable service and whether the standard charges included in the list apply at that location to the provision of that shoppable service in an inpatient setting, an outpatient department setting, or in both of those settings, as applicable; and

(B) indicate if one or more of the shoppable services specified by the Centers for Medicare and Medicaid Services is not provided by the facility.

(e) The list required under Subsection (a) or (c), as applicable, must be:

(1) displayed in the manner prescribed by Section [insert chapter number here].003(e) for the list required under that section;

(2) available:

(A) free of charge;

(B) without having to register or establish a user account or password;

- (C) without having to submit personal identifying information; and
  - (D) without having to overcome any other impediment, including entering a code to access the list;
- (3) searchable by service description, billing code, and payor;
  - (4) updated in the manner prescribed by Section [insert chapter number here].003(h) for the list required under that section;
  - (5) accessible to a common commercial operator of an Internet search engine to the extent necessary for the search engine to index the list and display the list as a result in response to a search query of a user of the search engine; and
  - (6) formatted in a manner that is consistent with the format prescribed by the [insert relevant state health agency] under Section [insert chapter number here].003(f)(3).

Sec. [insert chapter number here].005. REPORTING REQUIREMENT.

Each time a facility updates a list as required under Sections [insert chapter number here].003(h) and [insert chapter number here].004(e)(4), the facility must submit the updated list to the [insert relevant state health agency]. The [insert relevant state health agency] must prescribe the form in which the updated list must be submitted to the [insert relevant state health agency].

Sec. [insert chapter number here].006. MONITORING AND ENFORCEMENT.

(a) The [insert relevant state health agency] must monitor each facility's compliance with the requirements of this chapter using any of the following methods:

- (1) evaluating complaints made by persons to the [insert relevant state health agency] regarding noncompliance with this chapter;
- (2) reviewing any analysis prepared regarding noncompliance with this chapter;
- (3) auditing the Internet websites of facilities for compliance with this chapter; and
- (4) confirming that each facility submitted the lists required under Section [insert chapter number here].005.

(b) If the [insert relevant state health agency] determines that a facility is not in compliance with a provision of this chapter, the [insert relevant state health agency] must take the following actions:

- (1) provide a written notice to the facility that clearly explains the manner in which the facility is not in compliance with this chapter;

(2) request a corrective action plan from the facility if the facility has materially violated a provision of this chapter, as determined under Section [insert chapter number here].007; and

(3) impose an administrative penalty, as determined in Section [insert chapter number here].008 on the facility and publicize the penalty on the [insert relevant state health agency] Internet website if the facility fails to:

(A) respond to the [insert relevant state health agency] request to submit a corrective action plan; or

(B) comply with the requirements of a corrective action plan submitted to the [insert relevant state health agency].

(c) Beginning not later than 90 days after the date of the enactment of this Act, the [insert relevant state health agency] must create and maintain a publicly available list on its website of hospitals that have been found to have violated the hospital price transparency rule, that has been issued an administrative penalty or sent a warning notice, a request for a corrective action plan, or any other written communication from the [insert relevant state agency]. Such penalties, notices, and communications must be subject to public disclosure under 5 U.S.C. 552, notwithstanding any exemptions or exclusions to the contrary, in full without redaction. Such list will be updated at least every 30 days thereafter.

(d) Notwithstanding any provision of law to the contrary, in considering an application for renewal of a hospital's license or certification, the Department must consider whether the hospital is or has been in compliance with hospital price transparency laws.

Sec. [insert chapter number here].007. MATERIAL VIOLATION; CORRECTIVE ACTION PLAN.

(a) A facility materially violates this chapter if the facility fails to:

(1) comply with the requirements of Section [insert chapter number here].002; or

(2) publicize the facility's standard charges in the form and manner required by Sections [insert chapter number here].003 and [insert chapter number here].004.

(b) If the [insert relevant state health agency] determines that a facility has materially violated this chapter, the [insert relevant state health agency] must issue a notice of material violation to the facility and request that the facility submit a corrective action plan. The notice must indicate the form and manner in which the corrective action plan must be submitted to the [insert relevant state health agency], and clearly state the date by which the facility must submit the plan.

(c) A facility that receives a notice under Subsection (b) must:

(1) submit a corrective action plan in the form and manner, and by the specified date, prescribed by the notice of violation; and



(2) as soon as practicable after submission of a corrective action plan to the [insert relevant state health agency], act to comply with the plan.

(d) A corrective action plan submitted to the [insert relevant state health agency] must:

(1) describe in detail the corrective action the facility will take to address any violation identified by the [insert relevant state health agency] in the notice provided under Subsection (b); and

(2) provide a date by which the facility will complete the corrective action described by Subdivision (1).

(e) A corrective action plan is subject to review and approval by the [insert relevant state health agency]. After the [insert relevant state health agency] reviews and approves a facility's corrective action plan, the [insert relevant state health agency] must monitor and evaluate the facility's compliance with the plan.

(f) A facility is considered to have failed to respond to the [insert relevant state health agency] request to submit a corrective action plan if the facility fails to submit a corrective action plan:

(1) in the form and manner specified in the notice provided under Subsection (b); or

(2) by the date specified in the notice provided under Subsection (b).

(g) A facility is considered to have failed to comply with a corrective action plan if the facility fails to address a violation within the specified period of time contained in the plan.

Sec. [insert chapter number here].008. ADMINISTRATIVE PENALTY.

(a) The [insert relevant state health agency] must impose an administrative penalty on a facility in accordance with [insert relevant state code section] if the facility fails to:

(1) respond to the [insert relevant state health agency] request to submit a corrective action plan; or

(2) comply with the requirements of a corrective action plan submitted to the [insert relevant state health agency].

(b) The [insert relevant state health agency] must impose an administrative penalty on a facility for a violation of each requirement of this chapter. The [insert relevant state health agency] must set the penalty in an amount sufficient to ensure compliance by facilities with the provisions of this chapter subject to the limitations prescribed by Subsection (c).

(c) For a facility with one of the following total gross revenues as reported to the Centers for Medicare and Medicaid Services or to another entity designated by [insert relevant state health agency] rule in the year preceding the year in which a penalty is imposed, the penalty imposed by the [insert relevant state health agency] must not be lower than:

“(i) in the case of a hospital with a six-bed count of 30 or fewer, \$600 for each day in which the hospital fails to comply with such requirements;

“(ii) in the case of a hospital with a bed count that is greater than 30 and equal to or fewer than 550, \$20 per bed for each day in which the hospital fails to comply with such requirements; or

“(iii) in the case of a hospital with a bed count that is greater than 550, \$11,000 for each day in which the hospital fails to comply with such requirements

(d) Each day a violation continues is considered a separate violation.

(e) In determining the amount of the penalty, the [insert relevant state health agency] must consider:

- (1) previous violations by the facility’s operator;
- (2) the seriousness of the violation;
- (3) the demonstrated good faith of the facility’s operator; and
- (4) any other matters as justice may require.

(f) An administrative penalty collected under this chapter must be deposited to the credit of an account in the general revenue fund administered by the [insert relevant state health agency]. Money in the account must be appropriated only to the [insert relevant state health agency].

#### Sec. [insert chapter number here].009. LEGISLATIVE RECOMMENDATIONS.

The [insert relevant state health agency] must propose to the legislature recommendations for amending this chapter, including recommendations in response to amendments by the Centers for Medicare and Medicaid Services to 45 C.F.R. Part 180.

#### CHAPTER [insert chapter number here]. PROHIBITING COLLECTIVE ACTION OF DEBT AGAINST PATIENTS FOR NON-COMPLIANT FACILITIES:

##### Sec. [insert chapter number here].001. DEFINITIONS.

As used in this section, unless the context otherwise requires:

(1) “Collection action” means any of the following actions taken with respect to a debt for items and services that were purchased from or provided to a patient by a hospital on a date during which the hospital was not in material compliance with hospital price transparency laws:

- (a) Attempting to collect a debt from a patient or patient guarantor by referring the debt, directly or indirectly, to a debt collector, a collection agency, or other third party retained by or on behalf of the hospital;

(b) Suing the patient or patient guarantor, or enforcing an arbitration or mediation clause in any hospital documents including contracts, agreements, statements, or bills; or

(c) Directly or indirectly causing a report to be made to a consumer reporting agency.

(2) (a) "Collection agency" means any:

(i) Person who engages in a business the principal purpose or which is the collection of debts; or

(ii) Person who:

(a) Regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due to another;

(b) Takes assignment of debts for collection purposes; or

(c) Directly or indirectly solicits for collection debts owed or due or asserted to be owed or due to another.

(3) (a) "Consumer reporting agency" means any person that, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages, in whole or in part, in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties. "Consumer reporting agency" includes any person defined in 15 U.S.C. sec. 1681a (f) or section 5-18-103 (4).

(b) "Consumer reporting agency" does not include any business entity that provides check verification or check guarantee services only.

(4) (a) "Debt" means any obligation or alleged obligation of a consumer to pay money arising out of a transaction, whether or not the obligation has been reduced to judgment.

(b) "Debt" does not include a debt for business, investment, commercial, or agricultural purposes or a debt incurred by a business.

(5) "Debt collector" means any person employed or engaged by a collection agency to perform the collection of debts owed or due or asserted to be owed or due to another.

(6) "Federal Centers for Medicare and Medicaid Services" or "CMS" means the Center for Medicare and Medicaid Services in the United States Department of Health and Human Services.

(7) "Hospital" means, consistent with 45 CFR 180.20, a hospital:

(a) Licensed or certified by the Department pursuant to Section 25-1.5-103 (1)(a);  
or

(b) Approved by the Department as meeting the standards established for licensing a hospital.

(8) "Hospital price transparency laws" means Section 2718(e) of the "Public Health Service (PHS) Act," Pub.L. 78-410, as amended, and rules adopted by the United States Department of Health and Human Services implementing section 2718(e).

(9) "Items and services" or "items or services" means "items and services" as defined in 45 CFR 180.20.25-3-803.

Sec. [insert chapter number here].002. Failure to comply with hospital price transparency laws – prohibiting collection of debt – penalty.

(1) (a) Except as provided in Subsection (1)(b) of this section, on and after the effective date of this section, a hospital that is not in material compliance with hospital price transparency laws on the date that items or services are purchased from or provided to a patient by the hospital must not initiate or pursue a collection action against the patient or patient guarantor for a debt owed for the items or services.

(b) This Part [insert part name] applies, on and after [Insert applicable date here], to critical access hospitals licensed and certified by the Department pursuant to 42 CFR 485 Subpart F.

(2) If a patient believes that a hospital was not in material compliance with hospital price transparency laws on a date on or after the effective date of this section that items or services were purchased by or provided to the patient, and the hospital takes a collection action against the patient or patient guarantor, the patient or patient guarantor may file suit to determine if the hospital was materially out of compliance with the hospital price transparency laws and rules and regulations on the date of service, and the noncompliance is related to the items or services. The hospital must not take a collection action against the patient or patient guarantor while the lawsuit is pending.

(3) A hospital that has been found by a judge or jury, considering compliance standards issued by the Federal Centers for Medicare and Medicaid Services, to be materially out of compliance with hospital price transparency laws and rules and regulations:

(a) Must refund the payer any amount of the debt the payer has paid and must pay a penalty to the patient or patient guarantor in an amount equal to the total amount of the debt;

(b) Must dismiss or cause to be dismissed any court action with prejudice and pay any attorney fees and costs incurred by the patient or patient guarantor relating to the action; and

(c) Remove or cause to be removed from the patient's or patient guarantor's credit report any report made to a consumer reporting agency relating to the debt.

(4) Nothing in this Part [insert part name]:

(a) Prohibits a hospital from billing a patient, patient guarantor, or third-party payer, including health insurer, for items or services provided to the patient; or

(b) Requires a hospital to refund any payment made to the hospital for items or services provided to the patient, so long as no collection action is taken in violation of this Part [insert part name here].