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NCOIL ADOPTS TWO NEW HEALTH INSURANCE MODEL LAWS AT SUMMER MEETING IN MINNEAPOLIS

Model Laws Include the NCOIL Biomarker Testing Insurance Coverage Model Act and NCOIL Hospital Price Transparency Model Act

Belmar, NJ – At the 2023 National Council of Insurance Legislators (NCOIL) Summer National Meeting in Minneapolis, the organization adopted two new NCOIL Model Laws. The Models were first adopted by the group’s Health Insurance and Long-Term Care Issues Committee (Committee), Chaired by West Virginia Delegate Steve Westfall, and passed by NCOIL as a whole on Saturday July 22nd.

The two new Models are the NCOIL Biomarker Testing Insurance Coverage Model Act, sponsored by New York Assemblywoman Pamela Hunter, NCOIL Treasurer, and co-sponsored by Minnesota Senator Paul Utke, NCOIL Secretary, and the NCOIL Hospital Price Transparency Model Act sponsored by Texas Representative Tom Oliverson, M.D., NCOIL Vice President, and co-sponsored by Kentucky Representative Rachel Roberts, Vice Chair of the Committee.

Del. Westfall said, “The Committee has worked tirelessly to get these two Models to a place where they could be considered and I thank the sponsors and co-sponsors for listening to and incorporating input from a wide range of perspectives during the drafting and deliberation process. Hospital price transparency and health insurance coverage for biomarker testing are two issues of great interest to the public and these Models will provide effective guidance for legislators to bring back to their states.”

“I was pleased to see the committee adopt two bills that are so important in helping patients to navigate the healthcare marketplace,” said Arkansas Representative Deborah Ferguson, DDS, NCOIL President, “I am confident that these Models will prove to be very useful to legislators and I’ll be watching with great interest as bills based on the Models are introduced in legislatures across the country.”

The NCOIL Biomarker Testing Insurance Coverage Model Act requires insurance coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing

monitoring of a covered person's disease or condition. Approximately ten states have enacted similar legislation, with another ten states having introduced bills that largely mirror the Model.

The Model is intended to only apply post-diagnosis, and will help give more patients the ability to have a biomarker test conducted to guide treatment decisions in instances when the test provides clinical utility as demonstrated by medical and scientific evidence, including, but not limited to: labeled indications for a test approved or cleared by the Food and Drug Administration (FDA) of the United State government or indicated tests for an FDA approved drug; Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or nationally recognized clinical practice guidelines.

“The passage of this Model is an important step in making sure patients are able to make the best-informed decisions about the treatment options available to them when they need it most,” said Asw. Hunter. “We heard a range of differing opinions on this issue, but as NCOIL continues to prove, we were able to come together and adopt a Model on a vitally important issue that can be used to protect patients all across the country.”

During the drafting and deliberation process, NCOIL legislators and staff heard from a wide array of interested parties including: America's Health Insurance Plans (AHIP); the American Cancer Society Cancer Action Network; Biotechnology Innovation Organization (BIO); Blue Cross Blue Shield Association; California Health Benefits Review Program (CHBRP); ERISA Industry Committee (ERIC); GO2 Foundation for Lung Cancer; International Foundation for Autoimmune & Autoinflammatory Arthritis; National Comprehensive Cancer Network (NCCN); Ochsner Cancer Institute; and the UC San Diego Moore Cancer Center.

The NCOIL Hospital Price Transparency Model Act will enable states to implement laws and regulations that mandate healthcare facilities to disclose prices for specific items and services, offering patients accessible and transparent pricing information. Facilities will be required to maintain a list of standard charges for their items and services as well as provide a consumer-friendly list of shoppable services available at the facility. Non-compliance can result in a corrective action plan, administrative penalties, and a prohibition of collective debt actions against patients. The genesis for the Model and similar state laws is a very similar federal hospital price transparency regulation that hospitals have not been fully compliant with.

Rep. Oliverson said, “Lack of transparency in hospital pricing over the years has resulted in a lack of competition in the marketplace and led to rising healthcare costs across the nation. Unfortunately, this has made healthcare unaffordable for many Americans. This Model, combined with increased compliance with the federal regulation, will help ensure that consumers are empowered to make the best healthcare decisions for themselves and their families.”

During the drafting and deliberation process, the Committee heard from a wide array of interested parties including: the American Hospital Association (AHA); the Cicero Institute; the Council for Affordable Health Coverage; the National Academy for State Health Policy (NASHP); PatientRightsAdvocate.org; and the Texas Public Policy Foundation.

NCOIL CEO Commissioner Tom Considine said, “The passage of these two Models really underscores how NCOIL continues to be on the cutting edge of emerging healthcare public policy issues. It also shows NCOIL’s commitment to hearing different perspectives on all types of issues and being willing to make changes to Models throughout the drafting process. These are two issues that are very important to consumers so kudos to the Committee for working hard to reach a bipartisan consensus and getting these models over the finish line.”

A full copy of the models are below.

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NCOIL is a national legislative organization with the nation’s 50 states as members, represented principally by legislators serving on their states’ insurance and financial institutions committees. NCOIL writes Model Laws in insurance and financial services, works to preserve the State jurisdiction over insurance as established by the McCarran-Ferguson Act over seventy years ago, and to serve as an educational forum for public policymakers and interested parties. Founded in 1969, NCOIL works to assert the prerogative of legislators in making State policy when it comes to insurance and educate State legislators on current and longstanding insurance issues.

National Council of Insurance Legislators (NCOIL)

Biomarker Testing Insurance Coverage Model Act

**Sponsored by Asw. Pam Hunter (NY) – NCOIL Treasurer*

**Co-sponsored by Sen. Paul Utke (MN) – NCOIL Secretary*

**Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on July 20, 2023 and the NCOIL Executive Committee on July 22, 2023.*

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Section 1. Title

This Act shall be known and cited as the “[State] Biomarker Testing Insurance Coverage Act.”

Section 2. Definitions

(a) “Biomarker” means a defined characteristic that is measured as an indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions. Molecular, histologic, radiographic, or physiologic characteristics are types of biomarkers. A biomarker is not an assessment of how a patient feels, functions, or survives.

(b) “Biomarker testing” means the analysis of a patient’s tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests and multi-plex panel tests performed at a participating in-network laboratory facility that is either CLIA certified or CLIA waived by the federal food and drug administration.

(c) “Clinical utility” means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient’s outcome and impacts the clinical decision.

(d) “Nationally recognized clinical practice guidelines” as used here are evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

Section 3. Health Insurer Requirements

(a) Health insurers, nonprofit health service plans, and health maintenance organizations issuing, amending, delivering or renewing a health insurance contract on or after [DATE] shall include coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a covered person’s disease or condition to guide treatment decisions when the test provides clinical utility to the patient as demonstrated by medical and scientific evidence, including, but not limited to:

1. labeled indications for a test approved or cleared by the Food and Drug Administration (FDA) of the United States government or indicated tests for an FDA approved drug;
2. Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or
3. Nationally recognized clinical practice guidelines.

(b) Such coverage shall be provided in a manner that shall limit disruptions in care including the need for multiple biopsies or biospecimen samples.

(c) The covered person and prescribing practitioner shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy provided pursuant to the provisions of this Section. Such process shall be made readily accessible on the health insurer's, nonprofit health service plan's, or health maintenance organization's website.

(d) Nothing in this Section shall be construed to require coverage of biomarker testing for screening purposes.

Section 4. Medicaid Coverage Requirements

(a) The State Medical Assistance Program (Medicaid Program) shall cover biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a recipient's disease or condition to guide treatment decisions when the test provides clinical utility to the patient as demonstrated by medical and scientific evidence, including, but not limited to:

1. labeled indications for a test approved or cleared by the Food and Drug Administration (FDA) of the United States government or indicated tests for an FDA approved drug;
2. Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or
3. Nationally recognized clinical practice guidelines.

(b) Risk-bearing entities contracted to the Medicaid Program to deliver services to recipients shall provide biomarker testing at the same scope, duration and frequency as the Medicaid program otherwise provides to enrollees.

(c) The recipient and participating provider shall have access to a clear, readily accessible, and convenient processes to request an exception to a coverage policy of the Medicaid Program or by risk-bearing entities contracted to the Medicaid Program. Such process shall be made readily accessible to all participating providers and enrollees online.

(d) Nothing in this Section shall be construed to require coverage of biomarker testing for screening purposes.

Section 5. Rules

The Commissioner shall adopt rules as necessary to effectuate the provisions of this Act.

Section 6. Effective Date

This Act shall take effect [xxxxxx] and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

National Council of Insurance Legislators (NCOIL)

Hospital Price Transparency Model Act

**Sponsored by Rep. Tom Oliverson (TX), M.D. – NCOIL Vice President*

**Co-sponsored by Rep. Rachel Roberts (KY)*

**Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on July 20, 2023, and the NCOIL Executive Committee on July 22, 2023.*

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Section 1. Short Title

This Act shall be known and may be cited as the [State] 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. Definitions

(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) “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.

(5) “Collection agency” means any:

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

(b) Person who:

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

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

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

(6) “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 [insert citation to appropriate state law].
“Consumer reporting agency” does not include any business entity that provides check verification or check guarantee services only.

(7) “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. “Debt” does not include a debt for business, investment, commercial, or agricultural purposes or a debt incurred by a business.

(8) “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.

(9) “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.

(10) “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.

(11) “Discounted cash price” means the charge that applies to an individual who pays cash, or a cash equivalent, for a facility item or service.

(12) “Facility” means a hospital licensed under [insert appropriate state law].

(13) “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.

(14) “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.

(15) “Gross charge” means the charge for a facility item or service that is reflected on a facility’s chargemaster, absent any discounts.

(16) “Hospital” means, consistent with 45 CFR 180.20, a hospital:

(a) Licensed or certified by the [Department] pursuant to [insert citation to appropriate state law]; or

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

(17) “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).

(18) “Items and services” or “items or services” means “items and services” as defined in 45 CFR 180.20.25-3-803.

(19) “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.

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

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

(22) “Shoppable service” means a service that may be scheduled by a health care consumer in advance.

(23) “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.

(24) “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.

Section 4. Healthcare Facilities Required to Disclose Certain Prices to Patients/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 5 of this Act; and
- (2) a consumer-friendly list of standard charges for a limited set of shoppable services as provided in Section 6 of this Act.

Section 5. 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.

Section 6. 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 Section 5 of this Act 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 5 of this Act 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 5 of this Act 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 5 of this Act.

Section 7. Reporting Requirement

Each time a facility updates a list as required under Sections 5 and 6 of this Act, 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].

Section 8. 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 7 of this Act.

(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 9 of this Act; and

(3) impose an administrative penalty, as determined in Section 10 of this Act 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.

Section 9. Material Violation; Corrective Action Plan

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

(1) comply with the requirements of Section 4 of this Act; or

(2) publicize the facility's standard charges in the form and manner required by Sections 5 and 6 of this Act.

(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.

Section 10. 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].

Section 11. 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.

Section 12. Prohibiting Collective Action of Debt Against Patients for Non-Compliant Facilities

- (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 Section 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 Section:

(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 Section.

Section 13. Rules

The [insert relevant state health agency] shall adopt rules as necessary to effectuate the provisions of this Act.

Section 14. Effective Date

This Act shall take effect xxxxxx.

