I

111TH CONGRESS
2D SESSION

H. R. 4803

To ensure health care consumer and provider access to certain health benefits plan information and to amend title XIX of the Social Security Act to provide transparency in hospital price and quality information.

IN THE HOUSE OF REPRESENTATIVES

MARCH 10, 2010

Mr. BARTON of Texas (for himself, Mr. GENE GREEN of Texas, Mr. BURGESS, and Mr. STUPAK) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To ensure health care consumer and provider access to certain health benefits plan information and to amend title XIX of the Social Security Act to provide transparency in hospital price and quality information.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Patients' Right to Know Act''.

SEC. 2. HEALTH BENEFITS PLAN INFORMATION TRANSPARENCY.

(a) ENSURING CONSUMER AND PROVIDER ACCESS TO HEALTH BENEFITS PLAN INFORMATION.—

(1) IN GENERAL.—Each entity offering a health benefits plan (as defined in subsection (d)) shall make available to enrollees and potential enrollees of such plan the following information:

(A) The items and services that are included as part of the coverage offered by such plan and the items and services that are not so included.

(B) An explicit and clear list of limitations and restrictions in the health insurance coverage offered, along with a description of such limitations and restrictions.

(C) A description of the process available for appealing coverage decisions made by such plan.

(D) The number of appeals related to coverage decisions made during the previous calendar year and the outcomes of such appeals.

(E) The amount of cost-sharing (including premiums, deductibles, copayments, co-insurance, maximum possible annual out-of-pocket expenditure, and maximum possible lifetime

out-of-pocket expenditure) required by such plan.

(F) The number of participating providers according to medical specialty type.

(G) The extent to which a particular health care provider accepts coverage provided by such plan and the extent to which such a provider participates in the provider network of such plan.

(H) The percentage of total expenditures made by such plan during the previous calendar year that are attributable to administrative costs and an explanation of all the assumptions and factors used to calculate such percentage.

(I) The plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on enrollment and disenrollment, data on the number of claims denials, data on rating practices, information on cost-sharing and payments with respect to in-network and out-of-network coverage, and any other information determined by the Secretary of Health and Human Services to be beneficial to consumers or medical providers.

(J) Information the Secretary of Health and Human Services deems appropriate regarding the amount of waste and fraud in the operations of such plan, efforts to address such waste and fraud, and the outcomes of such efforts.

The requirement under this paragraph (including subparagraph (H)) shall apply only to entities offering health benefits plans (as defined in subsection (d)).

(2) OUT-OF-POCKET COST-SHARING TRANSPARENCY.—

(A) IN GENERAL.—An entity offering a health benefits plan shall disclose, upon request of an enrollee of such plan, the amount of out-of-pocket cost-sharing (including deductibles, copayments, and coinsurance) under such plan that the enrollee would be responsible for paying with respect to the furnishing of a specific item or service by a provider participating in such plan in a timely manner. At a minimum, such information shall be made available to the enrollee, upon request, prior to seeking care, and shall be provided in a manner that allows

such enrollee to compare providers based on such information.

(B) HEALTH CARE QUALITY INFORMATION TO BE DISCLOSED.—In disclosing information described in subparagraph (A), an entity offering a health benefits plan shall, to the extent practicable and appropriate, associate such information with any available risk-adjusted quality data measures. The Secretary may specify that such measures include those that have been endorsed by the National Quality Forum.

(3) ADVANCE NOTICE OF PLAN CHANGES.—An entity offering a health benefits plan shall not make a change to such plan without reasonable and timely advance notice of such change to enrollees of such plan.

(4) CONTRACTING REIMBURSEMENT TRANSPARENCY.—An entity offering a health benefits plan shall disclose to each health care provider information relating to the reimbursement arrangements between such plan and such provider.

(b) ADMINISTRATIVE PROVISIONS AND INFORMATION DESIGN.—

(1) TIMELY DISCLOSURE AND UPDATES; ADDITIONAL INFORMATION DISCLOSURES.—

(A) TIMELY DISCLOSURE AND UPDATES.—Each entity offering a health benefits plan shall provide for timely access to information described in subsection (a) and consistent with such subsection, including through an Internet website. Such information shall first be made available not later than 18 months after the date of the enactment of this Act. Such information shall be updated as often as is deemed feasible by the Secretary of Health and Human Services, but not less than once a calendar quarter.

(B) ADDITIONAL INFORMATION DISCLOSURES.—The Secretary may undertake rulemaking as necessary in order to ensure that additional information, as specified by the Secretary, is progressively made available by entities offering health benefits plans, in order to provide for the maximum feasible reporting of information to meet the needs of consumers and providers of health care in making determinations with regard to health care items, insurance, and services. In no case shall such additional information be required to be made available by any entity other than an entity offering

a health benefits plan (as defined in subsection (d)).

(2) INFORMATION DESIGN.—

(A) IN GENERAL.—Each entity offering a health benefits plan shall ensure that the information described in paragraph (1) is made available in a manner that—

(i) is in a format that is easily accessible, useable, and understandable to enrollees and potential enrollees of the plan as well as health care providers as applicable;

(ii) uses language that the intended audience can readily understand and that is clean, concise, well-organized, and follows other best practices of language writing; and

(iii) to the greatest extent feasible, permits an individual to search the information by a user-defined geographic area, such as within a 50-mile radius of the user's home address.

(B) ENABLING CONSUMERS TO COMPARE INFORMATION.—The Secretary of Health and Human Services shall, by final rule issued not

later than 12 months after the date of the enactment of this Act, require entities offering health benefits plans to disclose the information described in subsection (a)(1) in such a format as to allow individuals to compare the coverage options available to them in as uniform a manner as possible.

(c) PENALTY.—The Secretary shall provide for a methodology to impose a penalty fee against each entity offering a health benefits plan that fails to substantially meet the requirements of subsections (a) and (b). Such methodology shall—

(1) provide for an increased penalty amount in the case of such an entity that knowingly misrepresents information required to be disclosed under subsection (a) or under regulations issued pursuant to subsection (b)(1)(B);

(2) vary the amount of such fee based on the size of the entity involved and type of infraction.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a penalty fee imposed under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(d) ENTITY OFFERING A HEALTH BENEFITS PLAN DEFINED.—For the purposes of this section, the term

''entity offering a health benefits plan'' means a health insurance issuer with respect to the offering of health insurance coverage, including in the individual market and small and large group market (as such terms are defined in section 2791 of the Public Health Service Act); a plan sponsor with respect to the offering of a group health plan (as defined in such section 2791); and entities responsible for the administration of governmental health plans (including the Centers for Medicare & Medicaid Services with respect to the Medicare program under title XVIII of the Social Security Act, State agencies responsible for administration of State plans under the Medicaid program under title XIX of such Act or State child assistance plans under the State Children's Health Insurance Program under title XXI of such Act, and the Office of Personnel Management with respect to the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code).

SEC. 3. HOSPITAL AND AMBULATORY SURGICAL CENTER PRICE AND QUALITY TRANSPARENCY.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) by striking ''and'' at the end of paragraph (72);

(2) by striking the period at the end of paragraph (73) and inserting ''; and'';

(3) by inserting after paragraph (73) the following new paragraph:

''(74) provide that the State will establish and maintain laws, in accordance with the requirements of section 1921A, to require disclosure of information on hospital and ambulatory surgical center charges and quality, to make such information available to the public and the Secretary.''; and

(4) by inserting after section 1921 the following new section:

''SEC. 1921A. PRICE AND QUALITY TRANSPARENCY.

''(a) IN GENERAL.—The requirements referred to in section 1902(a)(74) are that the laws of a State must—

''(1) require reporting to a State (or its agent) by each hospital located therein, of information on—

''(A) the charges for inpatient and outpatient services typically performed (as defined by the Secretary through notice and comment rulemaking) by such hospital;

''(B) the reimbursement amount under title XVIII and under the State plan under this title for such services; and

''(C) if the hospital allows for or provides reduced charges for individuals based on financial need, the factors considered in making determinations for reductions in charges, including any formula for such determination and the contact information for the specific department of a hospital that responds to such inquiries;

''(2) provide for notice to individuals seeking or requiring such services of the availability of information on charges described in paragraph (1);

''(3) provide for timely access to such information, including at least through an Internet website, by individuals seeking or requiring such services; and

''(4) provide for timely access to information regarding the quality of care at each hospital made publicly available in accordance with section 501 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, section 1139A, or section 1139B.

''(b) APPLICATION TO AMBULATORY SURGICAL CENTERS.—The requirements described in subsection (a) shall apply, to the greatest extent practicable, to ambulatory surgical centers in the same manner as such requirements apply to hospitals, except that in applying paragraph (4)

of such subsection, the references described in such paragraph shall be deemed to be a reference to section 1833(i)(7).

''(c) CONSULTATION WITH STAKEHOLDERS.—For purposes of carrying out this section, the Secretary shall consult with appropriate stakeholders through a formal process to obtain guidance prior to issuing any implementing policies.

''(d) HOSPITAL DEFINED.—For the purposes of this section, the term 'hospital' means an institution that meets the requirements of paragraphs (1) and (7) of section 1861(e) and includes an institution to which section 1820(c) applies.

''(e) AMBULATORY SURGICAL CENTER DEFINED.—For purposes of this section, the term 'ambulatory surgical center' means a center described in section 1832(a)(2)(F)(i).''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to State plans beginning not later than 2 years after the date of the enactment of this Act.

(2) EXISTING PROGRAMS.—The Secretary of Health and Human Services shall establish a process by which a State with an existing program may cer-

tify to the Secretary that its program satisfies the requirements of section 1921A of the Social Security Act, as inserted by subsection (a).

○