HOUSE BILL NO. 689

INTRODUCED BY B. MERCER

A BILL FOR AN ACT ENTITLED: “AN ACT PROVIDING FOR PRICING TRANSPARENCY REQUIREMENTS FOR HOSPITALS; REQUIRING THE PUBLISHING OF STANDARD CHARGES AND CHARGES FOR SHOPPABLE SERVICES; PROVIDING FOR REQUIRED REPORTING TO THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; PROVIDING FOR ENFORCEMENT BY THE DEPARTMENT OF JUSTICE; PROVIDING FOR A PRIVATE RIGHT OF ACTION; PROVIDING NOTICE AND DISCLOSURE REQUIREMENTS FOR FACILITY FEES; REQUIRING REPORTING TO THE LEGISLATURE; PROHIBITING COLLECTION ACTIONS OF DEBT BY NONCOMPLIANT HOSPITALS; PROVIDING RULEMAKING AUTHORITY; AND PROVIDING DEFINITIONS.”

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Definitions.** As used in [sections 1 through 12], unless the context clearly indicates otherwise, the following definitions apply:

(1) "Ancillary service" means a hospital item or service that a hospital customarily provides as part of a shoppable service.

(2) "Chargemaster" means the list of all hospital items or services maintained by a hospital for which the hospital has established a charge.

(3) "Deidentified maximum negotiated charge" means the highest charge that a hospital has negotiated with all third-party payors for a hospital item or service.

(4) "Deidentified minimum negotiated charge" means the lowest charge that a hospital has negotiated with all third-party payors for a hospital item or service.

(5) "Department" means the department of public health and human services provided for in 2-15-2201.

(6) "Discounted cash price" means the charge that applies to an individual who pays cash or a cash equivalent for a hospital item or service.

(7) "Facility fee" means a fee charged or billed by a hospital for outpatient services provided in an off-campus health care facility, regardless of the modality through which the health care service is provided, that is:

(a) intended to compensate the health system or hospital for health care expenses; and

(b) separate and distinct from a professional fee.

(8) "Gross charge" means the charge for a hospital item or service that is reflected on the hospital's chargemaster, absent any discount.

(9) "Health system" means two or more health care facilities, with at least one being a hospital, that are owned by a common legal entity or that have entered into an affiliation agreement to combine or coordinate delivery of health care services under a common organizational name.

(10) "Hospital" has the same meaning as provided in 50-5-101.

(11) "Item or service" means an item or service, including a package of individual items or services, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge, and may include the following:

(a) a supply or procedure;

(b) room and board;

(c) the use of a hospital or other item;

(d) the service of a health care practitioner; or

(e) any other item or service for which a hospital has established a standard charge.

(12) "Machine-readable format" means a digital representation of information in a file that can easily be imported or read into a computer system for further processing without any additional preparation.

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

(14) "Professional fee" means a fee charged by a health care practitioner for medical services.

(15) "Shoppable service" means a service that may be scheduled by an individual in advance.

(16) "Standard charge" means the regular rate established by a hospital for a hospital item or service provided to a specific group of paying patients. The term includes the following:

(a) the gross charge;

(b) the payor-specific negotiated charge;

(c) the deidentified minimum negotiated charge;

(d) the deidentified maximum negotiated charge; and

(e) the discounted cash price.

(17) "Third-party payor" means an entity that is legally responsible for payment of a claim for a hospital item or service.

NEW SECTION. **Section 2. Required publishing of price information.** A hospital shall publish the following on the hospital's publicly accessible internet website and provide hard copies on request:

(1) a digital file in a machine-readable format and printable format that contains a list of all standard charges for all hospital items or services as provided in [section 3]; and

(2) a consumer-friendly and printable list of standard charges for a limited set of shoppable services as provided in [section 4].

NEW SECTION. **Section 3. List of standard charges -- publishing and formatting requirements -- department duties.** (1) A hospital has the following duties:

(a) maintain a list of all standard charges for all hospital items or services in accordance with [sections 1 through 7]; and

(b) ensure that the list is always available to the public, including publishing the list electronically in the manner specified under [section 2].

(2) The standard charges contained in the list under subsection (1)(a) must reflect the standard charges applicable to the location of the hospital, regardless of whether the hospital operates in more than one location or operates under the same license as another hospital.

(3) A hospital shall include the following information in the list under subsection (1)(a):

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

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

(i) the gross charge;

(ii) the deidentified minimum negotiated charge;

(iii) the deidentified maximum negotiated charge;

(iv) the discounted cash price;

(v) the payor-specific negotiated charge, including all payors and all plans accepted by the hospital in a manner clearly associated with the name of the third-party payor and specific plan and delineated by the name of the third-party payor and plan associated with the charge; and

(vi) a code used by the hospital for the purpose of accounting or billing for the hospital item or service, which may include the current procedural terminology code, the health care common procedure coding system, the diagnosis-related group code, the national drug code, or another common identifier.

(4) A hospital shall publish the information contained in the list under subsection (1) in a single digital file that is in a machine-readable format.

(5) (a) A hospital shall display the list under subsection (1) by posting the list in a prominent location on the home page of the hospital's publicly accessible internet website or by making the list accessible by a dedicated link that is prominently displayed on the home page of the hospital's publicly accessible internet website.

(b) If the hospital operates multiple locations and maintains a single internet website, the hospital shall post the list for each location that the hospital operates in a manner that clearly associates the list with the applicable location of the hospital and includes charges specific to each individual hospital location.

(6) (a) A hospital shall ensure that the list under subsection (1) is:

(i) available free of charge;

(ii) 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 in response to a search query of a user of the search engine;

(iii) formatted in a manner specified under [section 2] and this section and required by the department in administrative rule;

(iv) digitally searchable and printable by service description, billing code, and third-party payor; and

(v) in a format and identified by a naming convention specified by the department in administrative rule.

(b) The department shall ensure the list under subsection (1) does not require any of the following:

(i) the establishment of a user account or password or other information of the user;

(ii) the submission of personal identifying information; or

(iii) any other impediment, including entering a code to access the list.

(7) In determining the format of the list under subsection (1), the department shall develop a template that each hospital shall use in formatting the list. In developing the template required under this subsection (7), the department shall:

(a) take into consideration applicable federal guidelines for formatting similar lists required by federal law and ensure that the design of the template enables an individual to compare the charges contained in the lists maintained by each hospital; and

(b) design the template to be substantially like the template used by the centers for medicare and medicaid services for the purposes specified in [sections 2 through 7].

(8) A hospital shall update the list under subsection (1) no less than once a year. The hospital shall clearly indicate the date when the list was most recently updated, either on the list or in a manner that is clearly associated with the list. The hospital shall make available no less than the three most recent versions of the list.

NEW SECTION. **Section 4. List of shoppable services -- publishing and formatting requirements -- department duties.** (1) Except as provided under subsection (3), a hospital shall maintain and make publicly available a list of standard charges for each of at least 300 shoppable services provided by the hospital with charges specific to that individual hospital location. The hospital may select the shoppable services to be included in the list, except that the list must include the 70 services specified as shoppable services by the centers for medicare and medicaid services. If the hospital does not provide all the shoppable services specified by the centers for medicare and medicaid services, the hospital shall include all the shoppable services provided by the hospital.

(2) In selecting a shoppable service for the purpose of inclusion in the list under subsection (1), a hospital shall:

(a) consider how frequently the hospital provides the service and the hospital's billing rate for the service; and

(b) prioritize the selection of services that are among the services most frequently provided by the hospital.

(3) If the hospital providers fewer than 300 shoppable services, the hospital shall include in the list under subsection (1) the total number of shoppable services that the hospital provides in a manner that otherwise complies with the requirements of subsection (1).

(4) A hospital shall include all of the following information in the list of shoppable services under subsection (1):

(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 delineated 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 hospital does not offer a discounted cash price for a shoppable service or an ancillary service on the list, the gross charge for the shoppable service or ancillary service;

(d) the deidentified minimum negotiated charge that applies to each shoppable service included on the list and any ancillary service;

(e) the deidentified maximum negotiated charge that applies to each shoppable service included on the list and any ancillary service;

(f) a code used by the hospital for the purposes of accounting or billing for each shoppable service included on the list and any ancillary service, including the current procedural terminology code, the health care common procedure coding system code, the diagnosis-related group code, the national drug code, or another common identifier;

(g) if applicable, each location where the hospital provides a shoppable service and whether the standard charges included in the list apply to the provision of the shoppable service in an inpatient setting or an outpatient department setting at the location; and

(h) if applicable, an indication if a shoppable service specified by the centers for medicare and medicaid services is not provided by the hospital.

(5) (a) A hospital shall ensure that the list under subsection (1) is:

(i) available free of charge;

(ii) 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 in response to a search query of a user of the search engine;

(iii) formatted in a manner specified under [section 2] and this section and required by administrative rule;

(iv) digitally searchable and printable by service description, billing code, and third-party payor; and

(v) in a format and identified by a naming convention specified by the department in administrative rule.

(b) Nothing in this section may preclude a hospital from using a price estimator tool as provided for in 45 CFR 180.60 in addition to the list of shoppable services.

(c) The department shall ensure that the list under subsection (1) does not require any of the following:

(i) the establishment of a user account or password or other information of the user;

(ii) the submission of personal identifying information; or

(iii) any other impediment, including entering a code to access the list.

(6) In determining the format of the list under subsection (1), the department shall develop a template that each hospital shall use in formatting the list. In developing the template required under this subsection (6), the department shall:

(a) take into consideration applicable federal guidelines for formatting similar lists required by federal law and ensure that the design of the template enables an individual to compare the charges contained in the lists maintained by each hospital; and

(b) design the template to be substantially like the template used by the centers for medicare and medicaid services for the purposes specified in [sections 2 through 7].

(7) A hospital shall update the list under subsection (1) no less than once a year. The hospital shall clearly indicate the date when the list was most recently updated, either on the list or in a manner that is clearly associated with the list. The hospital shall make available no less than the three most recent versions of the list.

NEW SECTION. **Section 5. Reporting requirements -- report publishing.** (1) Each time a hospital creates or updates a list as required under [sections 3 and 4], the hospital shall submit the list, along with a report on the list, to the department. The department shall specify the form of the report in administrative rule.

(2) To be considered in compliance, a list received by the department must include a minimum of 95% of all values required under [sections 3 and 4].

(3) By July 1 of each year, a hospital shall report to the department on facility fees charged or billed during the preceding calendar year. The department shall specify the form of the report in administrative rule. The report must include:

(a) the name and location of each health care facility owned or operated by the hospital that provides services for which a facility fee is charged or billed;

(b) the number of patient visits at each health care facility for which a facility fee was charged or billed;

(c) the number, total amount, and types of allowable facility fees paid at each health care facility by medicare, medicaid, and private insurance;

(d) for each health care facility, the total number of facility fees charged and the total amount of revenue received by the hospital or health system derived from facility fees;

(e) the total amount of facility fees charged and the total amount of revenue received by the hospital or health system from all health care facilities derived from facility fees;

(f) the 10 most frequent procedures or services, identified by category I current procedural terminology codes, provided by the hospital that generated the largest amount of facility fee gross revenue, including:

(i) the volume of each procedure or service;

(ii) the gross and net revenue totals for each procedure or service; and

(iii) the total net amount of revenue received by the hospital or health system derived from facility fees for each procedure or service;

(g) the 10 most frequent procedures or services, based on patient volume and identified by category I current procedural terminology codes, provided by the hospital for which facility fees were billed or charged, including the gross and net revenue totals received for each procedure or service; and

(h) any other information related to facility fees the department may require.

(4) An authorized executive of the hospital or health system shall issue an unsworn written declaration, following the requirements of 1-6-105, stating that any report or list submitted to the department is complete and accurate to the best of the authorized executive's knowledge and belief.

(5) The department shall make all reports and lists available on its publicly accessible internet website within 60 days of receipt of each report.

(6) A health system may make the report for each hospital that it owns or operates, provided that each hospital has its own separate report.

NEW SECTION. **Section 6. Machine-readable format requirements.** For the purposes of [sections 2 through 7], a hospital shall meet the following conditions when providing digital files in a machine-readable format:

(1) the file must be formatted without additional rows or spacing between data;

(2) the file must be readily usable without additional instructions; and

(3) the file must be in a machine-readable format that is widely used by other hospitals for cross-comparison purposes, including a spreadsheet format that an individual with average computer skills can open, read, and comprehend.

NEW SECTION. **Section 7. Notice and disclosure of facility fees.** (1) A health care facility affiliated with or owned by a hospital that charges a facility fee shall disclose to a patient at the time an appointment is scheduled, and at the time medical services are rendered, that a facility fee may be charged.

(2) Disclosure of facility fees must occur on a plain language notice as determined in administrative rule. The notice must include:

(a) the dollar amount of the patient's potential financial liability for a facility fee if a diagnosis and extent of medical treatment is known;

(b) an estimated range in dollars of the patient's potential financial liability for a facility fee if the diagnosis and extent of medical treatment is unknown; and

(c) if applicable, a statement that the patient may incur a financial liability to the health care facility

that the patient would not incur if the patient was receiving medical services and treatment on the campus of the hospital.

NEW SECTION. **Section 8. Complaints.** The department shall establish an electronic form for individuals to submit complaints for alleged violations of [sections 2 through 7]. The department shall post the electronic form on its publicly accessible internet website. The department shall also accept complaints via a department customer service telephone number.

NEW SECTION. **Section 9. Violations -- civil enforcement -- private right of action.** (1) A violation of the provisions of [sections 2 through 7] is an unlawful practice under 30-14-103.

(2) A hospital that violates the provisions of [sections 2 through 7] is subject to any investigative or enforcement action available under Title 30, chapter 14, parts 1 and 2, including investigative demands, remedies, penalties, and the right to bring an individual action under 30-14-133.

(3) A person who suffers an injury caused by a violation of [sections 2 through 7] has a private right of action to seek damages, subject to the following conditions:

(a) the person reports the violation to the noncompliant hospital;

(b) the hospital fails to cure the violation; and

(c) at least 30 days have passed since the person reported the violation to the noncompliant hospital.

(4) A person who brings an action for damages under subsection (3) and prevails is entitled to attorney fees.

NEW SECTION. **Section 10. Rulemaking authority.** The department shall adopt rules necessary to implement [sections 1 through 8].

NEW SECTION. **Section 11. Report to the legislature.** The department shall report annually by September 1 to the children, families, health, and human services interim committee in accordance with 5-11-222 regarding the department's efforts under [sections 1 through 10].

NEW SECTION. **Section 12. Prohibition on collection action of debt against patients by noncompliant hospitals.** (1) Except as provided under subsection (4), a hospital may not initiate or pursue a collection action against a patient or patient guarantor for a debt owed for an item or service if the hospital is in violation of the requirements under [sections 2 through 7] on the date when the item or service is purchased by or provided to the patient.

(2) If a patient believes that a hospital is in violation of the requirements under [sections 2 through 7] on the date when an item or service is 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 initiate a civil action in the district court to determine if the hospital is in violation of [sections 2 through 7] and the noncompliance is related to the item or service. The hospital may not take a collection action against the patient or patient guarantor or submit a report to the patient's or patient guarantor's credit report while the civil action is pending.

(3) A hospital that has been determined to be in violation of the requirements under [sections 2 through 7] shall:

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

(b) dismiss or cause to be dismissed a civil action under subsection (2) 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 a report made to a consumer reporting agency relating to the debt.

(4) Nothing in this section may be construed to:

(a) prohibit a hospital from billing a patient, patient guarantor, or third-party payor, including a health insurer, for an item or service provided to the patient in a manner that is not in violation of this section; or

(b) require a hospital to refund a payment made to the hospital for an item or service provided to the patient if no collection action is taken in violation of [sections 2 through 7].

(5) As used in this section, the following definitions apply:

(a) "Collection action" means any of the following actions taken with respect to a debt for an item

or service that was purchased from or provided to a patient by a hospital on a date during which the hospital was not in material compliance with [sections 2 through 7]:

(i) 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;

(ii) bringing a civil legal action against the patient or patient guarantor or enforcing an arbitration or mediation clause in a hospital document, including any contract, agreement, statement, or bill; or

(iii) directly or indirectly causing a report to be made to a consumer reporting agency.

(b) "Collection agency" means any of the following:

(i) a person who engages in a business for the principal purpose of collecting debts;

(ii) a person who regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due to another; or

(iii) a person who directly or indirectly solicits for collection debts owed or due or asserted to be owed or due to another.

(c) (i) "Consumer reporting agency" means a person who, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages 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. The term includes "consumer reporting agency" as defined in 15 USC 1681a(f).

(ii) The term does not include a business entity that only provides check verification or check guarantee services.

(d) (i) "Debt" means an 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.

(ii) The term does not include a debt for business, investment, commercial, or agricultural purposes or a debt incurred by a business.

(e) "Debt collector" means a 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.

NEW SECTION. **Section 13. Codification instruction.** [Sections 1 through 12] are intended to be codified as a new part in Title 30, chapter 14, and the provisions of Title 30, chapter 14, apply to [sections 1

through 12].

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