

111TH CONGRESS
2^D 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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Patients’ Right to
5 Know Act”.

1 **SEC. 2. HEALTH BENEFITS PLAN INFORMATION TRANS-**
2 **PARENCY.**

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

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

9 (A) The items and services that are in-
10 cluded as part of the coverage offered by such
11 plan and the items and services that are not so
12 included.

13 (B) An explicit and clear list of limitations
14 and restrictions in the health insurance cov-
15 erage offered, along with a description of such
16 limitations and restrictions.

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

20 (D) The number of appeals related to cov-
21 erage decisions made during the previous cal-
22 endar year and the outcomes of such appeals.

23 (E) The amount of cost-sharing (including
24 premiums, deductibles, copayments, co-insur-
25 ance, maximum possible annual out-of-pocket
26 expenditure, and maximum possible lifetime

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

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

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

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

15 (I) The plan terms and conditions, claims
16 payment policies and practices, periodic finan-
17 cial disclosure, data on enrollment and disen-
18 rollment, data on the number of claims denials,
19 data on rating practices, information on cost-
20 sharing and payments with respect to in-net-
21 work and out-of-network coverage, and any
22 other information determined by the Secretary
23 of Health and Human Services to be beneficial
24 to consumers or medical providers.

1 (J) Information the Secretary of Health
2 and Human Services deems appropriate regard-
3 ing the amount of waste and fraud in the oper-
4 ations of such plan, efforts to address such
5 waste and fraud, and the outcomes of such ef-
6 forts.

7 The requirement under this paragraph (including
8 subparagraph (H)) shall apply only to entities offer-
9 ing health benefits plans (as defined in subsection
10 (d)).

11 (2) OUT-OF-POCKET COST-SHARING TRANS-
12 PARENCY.—

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

1 such enrollee to compare providers based on
2 such information.

3 (B) HEALTH CARE QUALITY INFORMATION
4 TO BE DISCLOSED.—In disclosing information
5 described in subparagraph (A), an entity offer-
6 ing a health benefits plan shall, to the extent
7 practicable and appropriate, associate such in-
8 formation with any available risk-adjusted qual-
9 ity data measures. The Secretary may specify
10 that such measures include those that have
11 been endorsed by the National Quality Forum.

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

17 (4) CONTRACTING REIMBURSEMENT TRANS-
18 PARENCY.—An entity offering a health benefits plan
19 shall disclose to each health care provider informa-
20 tion relating to the reimbursement arrangements be-
21 tween such plan and such provider.

22 (b) ADMINISTRATIVE PROVISIONS AND INFORMATION
23 DESIGN.—

24 (1) TIMELY DISCLOSURE AND UPDATES; ADDI-
25 TIONAL INFORMATION DISCLOSURES.—

1 (A) TIMELY DISCLOSURE AND UPDATES.—

2 Each entity offering a health benefits plan shall
3 provide for timely access to information de-
4 scribed in subsection (a) and consistent with
5 such subsection, including through an Internet
6 website. Such information shall first be made
7 available not later than 18 months after the
8 date of the enactment of this Act. Such infor-
9 mation shall be updated as often as is deemed
10 feasible by the Secretary of Health and Human
11 Services, but not less than once a calendar
12 quarter.

13 (B) ADDITIONAL INFORMATION DISCLO-
14 SURES.—The Secretary may undertake rule-
15 making as necessary in order to ensure that ad-
16 ditional information, as specified by the Sec-
17 retary, is progressively made available by enti-
18 ties offering health benefits plans, in order to
19 provide for the maximum feasible reporting of
20 information to meet the needs of consumers and
21 providers of health care in making determina-
22 tions with regard to health care items, insur-
23 ance, and services. In no case shall such addi-
24 tional information be required to be made avail-
25 able by any entity other than an entity offering

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

3 (2) INFORMATION DESIGN.—

4 (A) IN GENERAL.—Each entity offering a
5 health benefits plan shall ensure that the infor-
6 mation described in paragraph (1) is made
7 available in a manner that—

8 (i) is in a format that is easily acces-
9 sible, useable, and understandable to en-
10 rollees and potential enrollees of the plan
11 as well as health care providers as applica-
12 ble;

13 (ii) uses language that the intended
14 audience can readily understand and that
15 is clean, concise, well-organized, and fol-
16 lows other best practices of language writ-
17 ing; and

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

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

1 later than 12 months after the date of the en-
2 actment of this Act, require entities offering
3 health benefits plans to disclose the information
4 described in subsection (a)(1) in such a format
5 as to allow individuals to compare the coverage
6 options available to them in as uniform a man-
7 ner as possible.

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

13 (1) provide for an increased penalty amount in
14 the case of such an entity that knowingly misrepre-
15 sents information required to be disclosed under
16 subsection (a) or under regulations issued pursuant
17 to subsection (b)(1)(B);

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

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

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

1 “entity offering a health benefits plan” means a health
2 insurance issuer with respect to the offering of health in-
3 surance coverage, including in the individual market and
4 small and large group market (as such terms are defined
5 in section 2791 of the Public Health Service Act); a plan
6 sponsor with respect to the offering of a group health plan
7 (as defined in such section 2791); and entities responsible
8 for the administration of governmental health plans (in-
9 cluding the Centers for Medicare & Medicaid Services with
10 respect to the Medicare program under title XVIII of the
11 Social Security Act, State agencies responsible for admin-
12 istration of State plans under the Medicaid program under
13 title XIX of such Act or State child assistance plans under
14 the State Children’s Health Insurance Program under
15 title XXI of such Act, and the Office of Personnel Man-
16 agement with respect to the Federal Employees Health
17 Benefits Program under chapter 89 of title 5, United
18 States Code).

19 **SEC. 3. HOSPITAL AND AMBULATORY SURGICAL CENTER**
20 **PRICE AND QUALITY TRANSPARENCY.**

21 (a) IN GENERAL.—Section 1902(a) of the Social Se-
22 curity Act (42 U.S.C. 1396a(a)) is amended—

23 (1) by striking “and” at the end of paragraph
24 (72);

1 (2) by striking the period at the end of para-
2 graph (73) and inserting “; and”;

3 (3) by inserting after paragraph (73) the fol-
4 lowing new paragraph:

5 “(74) provide that the State will establish and
6 maintain laws, in accordance with the requirements
7 of section 1921A, to require disclosure of informa-
8 tion on hospital and ambulatory surgical center
9 charges and quality, to make such information avail-
10 able to the public and the Secretary.”; and

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

13 **“SEC. 1921A. PRICE AND QUALITY TRANSPARENCY.**

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

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

18 “(A) the charges for inpatient and out-
19 patient services typically performed (as defined
20 by the Secretary through notice and comment
21 rulemaking) by such hospital;

22 “(B) the reimbursement amount under
23 title XVIII and under the State plan under this
24 title for such services; and

1 “(C) if the hospital allows for or provides
2 reduced charges for individuals based on finan-
3 cial need, the factors considered in making de-
4 terminations for reductions in charges, includ-
5 ing any formula for such determination and the
6 contact information for the specific department
7 of a hospital that responds to such inquiries;

8 “(2) provide for notice to individuals seeking or
9 requiring such services of the availability of informa-
10 tion on charges described in paragraph (1);

11 “(3) provide for timely access to such informa-
12 tion, including at least through an Internet website,
13 by individuals seeking or requiring such services;
14 and

15 “(4) provide for timely access to information re-
16 garding the quality of care at each hospital made
17 publicly available in accordance with section 501 of
18 the Medicare Prescription Drug, Improvement, and
19 Modernization Act of 2003, section 1139A, or sec-
20 tion 1139B.

21 “(b) APPLICATION TO AMBULATORY SURGICAL CEN-
22 TERS.—The requirements described in subsection (a) shall
23 apply, to the greatest extent practicable, to ambulatory
24 surgical centers in the same manner as such requirements
25 apply to hospitals, except that in applying paragraph (4)

1 of such subsection, the references described in such para-
2 graph shall be deemed to be a reference to section
3 1833(i)(7).

4 “(c) CONSULTATION WITH STAKEHOLDERS.—For
5 purposes of carrying out this section, the Secretary shall
6 consult with appropriate stakeholders through a formal
7 process to obtain guidance prior to issuing any imple-
8 menting policies.

9 “(d) HOSPITAL DEFINED.—For the purposes of this
10 section, the term ‘hospital’ means an institution that
11 meets the requirements of paragraphs (1) and (7) of sec-
12 tion 1861(e) and includes an institution to which section
13 1820(c) applies.

14 “(e) AMBULATORY SURGICAL CENTER DEFINED.—
15 For purposes of this section, the term ‘ambulatory sur-
16 gical center’ means a center described in section
17 1832(a)(2)(F)(i).”

18 (b) EFFECTIVE DATE.—

19 (1) IN GENERAL.—The amendments made by
20 subsection (a) shall apply to State plans beginning
21 not later than 2 years after the date of the enact-
22 ment of this Act.

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

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

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