State	Bill	Status	Category	Summary	Sponsor
AK	HB 229/SB 201	Referred to House Labor and Commerce Committee/Referred to Senate Labor and Commerce Committee	APCD	This measure creates the Alaska Health Care Transformation Corporation to establish an all-payer claims database. The corporation will collect and analyze health care cost and quality data; create an objective, reliable, and comprehensive central repository of health care information; and provide researchers, policymakers, and the public with timely and transparent access to health care information.	Rep. Ivy Spohnholz (D)/Sen. Natasha Von Imhof (R)
AZ	HB 2294	Referred to House Rules, Appropriations, and HHS Committees	Transparency	This measure requires health plans to report: (a) the relative price paid to each health care provider, by provider type, with hospital inpatient and outpatient relative prices listed separately; (b) the annual rate of growth stated as a percentage of the average relative price by provider type; (c) a comparison of relative prices for the health plan's participating providers and show the variation in price as a percentage, identifying providers who are paid more than 10%, 15%, and 20% above the average relative price. The department must issue an annual report on this information.	Rep. Anthony Kern (R)
CA	AB 2830	Died in Senate Health Committee	APCD	This measure would move up the deadline for the Office of Statewide Health Planning and Development to administer the Health Care Cost Transparency Database to Jan. 1, 2022. It would also direct the office to take a number of steps to implement that database, including contracting with a data collection vendor and authorizing the office to impose a user fee on eligible users of the database. It also makes failure to comply with reporting a violation of the licensing law.	Asm. Jim Wood (D)
CA	AB 1038	Died in Health Committee	Transparency	This measure requires the Medical Board to provide the Office of Statewide Health Planning and Development a list of all physicians and surgeons licensed in California. The office may request: 1) the negotiated rate for each health care service plan or insurer that the physician and surgeon has a contract; 2) the charge for each service provided by the physician and surgeon; 3) if the physician and surgeon is a member of a risk-bearing organization, independent practice association, or other organized medical group, the group may provide this data if the office can determine from the provided data the negotiated rate for each service. The office must make public aggregate data indicating negotiated rates by physician and surgeon specialties by geographic region and negotiated rates compared to Medicare rates.	Asm Al Muratsuchi (D)
CA	AB 1404	Died in Assembly Appropriations Committee	Transparency	This measure requires a nonprofit corporation that operates or controls a health facility or is a licensed health care service plan to make specified annual disclosures publicly available on deferred compensation allocated by the nonprofit sponsor, the amount and type of compensation paid or allocated on behalf of each listed person, whether taxes were paid on the deferred compensation, and the applicable agreement or legal document governing the deferred compensation.	Asm. Miguel Santiago (D)
CA	AB 2817	Died in Assembly Health Committee	Cost Benchmark	This measure establishes the Office of Health Care Quality and Affordability to: analyze the health care market for cost trends and drivers of spending; develop data-informed policies for lowering health care costs; and create a strategy to control health care costs. This measure requires health care entities to report specified data to the board, which the board would be required to keep confidential. Based on that data, the board will annually establish statewide health care cost growth targets beginning in the 2022 calendar year and sector-based health care cost growth targets beginning in the 2023 calendar year.	Asm. Jim Wood (D)
CA	SB 977	Died In State Assembly	Other	This measure requires a health care system, private equity group, or hedge fund that is acquiring or affiliating with a provider, group of providers, or health care facility for a transactional value of $500,000 or less to provide written notice to the Attorney General. The Attorney General would be required to provide one of two specified notices within 30 days, either not objecting to the transaction or raising concerns, as specified. This measure also requires the Attorney General, beginning July 1, 2021, to establish the Health Policy Advisory Board, composed of specified appointed members, to evaluate and analyze health care markets in California and provide recommendations to the Attorney General's office. The board would review a written notification submitted by a health care system and provide the Attorney General with written information with regard to whether to grant or deny consent to the affiliation or acquisition. This measure would make it unlawful for one or more health care systems to use their market power to cause anticompetitive effects, and would authorize the Attorney General to bring a civil action for a violation of this unlawful conduct. Court imposed civil fines for these violations, calculated as the greater option between $1,000,000 or twice the gross gain to the health care system or gross loss to any other party multiplied by two, would be required. The fines would be deposited into the Attorney General antitrust account within the General Fund. A court would impose monetary relief for the state in the amount of three times the total damage sustained.	Sen. Bill Monning (D)

State	Bill	Status	Category	Summary	Sponsor
CO	HB 1349	Referred to House Appropriations Committee	Reference Pricing	This measure requires that a carrier that offers an individual health benefit plan in the state offer the Colorado Option Plan in the individual market. Among other requirements, there will be a base reimbursement rate to hospitals of 155% of hospitals' Medicare reimbursement rate or equivalent rate. A hospital that is a critical access hospital or independent will receive a 20% increase in the base reimbursement rate. A hospital that is both a critical access and independent must receive a 40% increase in reimbursement rates. A hospital with a combined percentage of Medicare and Medicaid reimbursement that exceeds the statewide average must receive up to a 30% increase in its base reimbursement rate. A hospital that is efficient in managing the underlying cost of care, taking into account the hospital's total margins, operating costs, and net patient revenue, must receive up to a 40% increase in its base reimbursement rate.	Rep. Dylan Roberts (D)
CT	HB 5487/SB 447	Referred to Joint Public Health Committee	Facility Fees	This measure requires hospitals, health systems, and hospital-based facilities to submit to the Health Planning Unit of the Office of Health Strategy a sample of a billing statement issued by the facility that complies with Connecticut's existing requirements for any billing statement that includes a facility fee. It also requires patient notices of facility fees to be published in the top 15 languages spoken in the state, as determined by the US Census Bureau. If a provider-based facility is purchased by a hospital at which facility fees may be billed, the hospital or health system must provide written notice to each patient served within the three years preceding the date of the transaction. Each hospital-based facility that was subject to this kind of transaction must report to the Health Systems Planning Unit the number of patient served by such hospital-based facility in the preceding three years, the number of patients notified in accordance with the provisions of this subsection and the types of delivery methods used to notify such patients, the number of patients that were notified by each delivery method and the date or dates such notifications were sent. This measure also expands Connecticut's limits on facility fees for outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) code to also include that no hospital, health system, or hospital-based facility can collect a facility fee for a CPT E/M code. It allows the Office of Health Strategy to prescribe the form in which hospitals and health systems report on facility fees charged or billed during the previous year. It also amends the reporting requirements to include the total amount of facility fees charged and the total amount of revenue received derived from facility fees as well as the the top 10 procedures for which facility fees are charged based on gross and net revenue received by the health system.	Joint Public Health Committee
CT	HB 5018/SB 328	Passed Joint Insurance and Real Estate Committee	Cost Benchmark	This measure directs the Office of Health Strategy to: set an annual health care cost growth benchmark and primary care target; enhance transparency of health care entities; monitor the development of accountable care organizations and patient-centered medical homes; and monitor the adoption of alternative payment methodologies in the state.	Rep. Joe Aresimowicz (D)/Senate Insurance and Real Estate Committee
DE	SB 171	Died in Senate	Facility Fees	This measure establishes standards with respect to safety and sanitary conditions of urgent care facilities and requires urgent care facilities to be licensed by the state. The department shall set forth a variety of regulations, including rules governing whether and under what circumstances and conditions a facility fee may be charged or added to the costs of services, provided to a patient by an urgent care facility.	Sen. Nicole Poore (D)
FL	SB 1626	Died in Senate Banking and Insurance Committee	Transparency	This measure prohibits a health insurer from limiting a contracted health care provider's ability to disclose to a patient whether their cost-sharing obligation exceeds the cash price for a covered service in the absence of health insurance coverage or the availability of a more affordable service. The measure also prohibits a health insurer from requiring an insured to pay an amount for covered services which exceeds the cash price of the service in the absence of health insurance coverage.	Sen. Anitere Flores (R)
FL	SB 1836	Died in Senate Appropriations Subcommittee on Agriculture, Environment, and General Government	Transparency	This measure requires the Agency for Health Care Administration to publish by July 1st of each year an annual report identifying identifying the health care services with the most significant price variation both statewide and regionally. The measure also revises the definition of the term "shoppable health care service" to include any additional services published by the Agency for Health Care Administration that have the most significant price variation.	Sen. Aaron Bean (R) and the Senate Governmental Oversight and Accountability Committee
FL	HB 919	Died in Senate Finance and Tax Committee	Community Benefit	This measure adjusts the criteria for determining the tax exemption status used by hospitals and includes the hospitals net community benefit. A hospital must include a copy of the hospital owner's most recent IRS Form 990, schedule H, and a statement of the net community benefit expense in the application for the exemption.	House Ways & Means Committee

State	Bill	Status	Category	Summary	Sponsor
GA	SB 482	Signed by Governor	APCD	This measure establishes the Georgia All-Payer Claims Database (APCD) Advisory Committee to make recommendations for a framework and implementation plan for an APCD. The advisory committee must make recommendations by March 1, 2021 and the Georgia APCD must be operational no later than Jan. 1, 2023.	Sen. Dean Burke (R)
GA	SB 151	Died in Senate Health and Human Services Committee	Transparency	This measure establishes the Office of Health Strategy and Coordination in the Office of the Governor. The office would bring together experts from academic institutions and industries, as well as state-elected and appointed leaders to provide a forum to share information, coordinate the major functions of the state's health care system, and develop innovative approaches for stabilizing costs while improving access to quality care. The office would also, among other things, propose cost management strategies, establish transparency in health care costs, and establish a statewide claims database. The office would also be tasked with convening the Data Access Forum to evaluate current health care database infrastructure, existing and needed funding, as well as recommending legislation needed to develop a common data platform for the state's health care system.	Sen. Dean Burke (R)
GA	SB 303	Signed by Governor	Transparency	This measure requires each insurer to make a publicly available website for members to compare payment amounts accepted by in-network providers, obtain estimates of the average amount accepted by an in-network provider and out-of-pocket costs, and compare quality metrics.	Sen. Ben Watson (R)
GA	SB 114	Died in Senate Regulated Industries and Utilities Committee	Study	This measure establishes the Health Strategies Council made up of health care facility representatives and regulating agencies. The council will serve as an advisory body to the department and review, comment, and make recommendations about the state health plan and conduct an ongoing evaluation of Georgia's existing health care resources for accessibility, quality, comprehensiveness, and cost. The council must make an annual report to the General Assembly and the initial report must include a review and description of certificate of need processes.	Sen. Dean Burke (R)
GA	HB 198/SB 74	Died in House	Other	This measure eliminates certificate of need requirements for all hospitals except certain long-term care facilities.	Rep. Matt Hatchett (R)/Sen. Matt Burgess (R)
HI	HB 1011/SB 1237	Carried over to 2020 session	APCD	This measure requires health insurance providers that provide Medicare Advantage health benefit plans to submit administrative data, including health care services claims and payment data, to the State Health Planning and Development Agency.	Rep. Scott Aiki (D)
HI	HB 1444	Carried over to 2020 session	Study	This measure establishes the Primary Care Payment Reform Collective to examine current levels of primary care spending, explore primary care mandates in other states, examine alternative methods of enhancing primary care spending, and exploring data collection issues related to understanding the state's primary care spending.	Rep. Della Belatti (D)
IA	SF 19	Referred to Senate Human Resources Committee	Transparency	This measure relates to the disclosure of the prices charged for health services rendered by health care providers and hospitals.	Sen. Brad Zaun (R)
IL	SB 1187	Referred to Senate Assignments Committee	Transparency	This measure requires carriers to develop and implement a program that provides incentives for enrollees who elect to receive a comparable health service from a provider that collects less than the average in-network amount. The carrier must provide the incentive as a cash payment, gift card, or credit towards the enrollee's annual in-network deductible. The incentive payment would not be considered an administrative expense for rate development purposes. Carriers must also develop an interactive tool to compare allowed amounts among network providers and estimate out-of-pocket costs. The state employee health plan must conduct an analysis of the cost-effectiveness of implementing an incentive-based program for enrollees.	Sen. Jim Overwise (R)
IL	SB 2561	Died via Passage Deadline	Telehealth	This measure requires an insurer providing telehealth services to reimburse the originating site a facility fee of $25 per telehealth service. The director of insurance has the power to increase or decrease the dollar amount of this facility fee as appropriate at least once every five years.	Sen. Laura Fine (D)
IL	SB 27	Senate Committee deadline passe; re-referred to Assignments	Telehealth	This measure requires that a health benefit policy or plan not exclude from coverage a medically necessary health care service or procedure delivered by a contracted health care professional or contracted health care provider solely because the health care service or procedure is provided through telehealth. It also requires any fee-for-service or managed-care medical assistance program to provide coverage of the cost of health care services provided through telehealth on the same basis and at the same contracted rate as established for coverage for providing the same service through in-person treatment. It requires a facility fee be paid to originating sites.	Sen. Andy Manar (D)

State	Bill	Status	Category	Summary	Sponsor
IN	SB 5	Signed by Governor	APCD	This measure requires hospitals, ambulatory outpatient surgical centers, and urgent care facilities to post certain information on their websites about health care services they provide, including the weighted average negotiated charges for the services. It also prohibits insurers from including in a health provider contract a provision under which a provider would be prohibited from disclosing health care service claims data to an employer providing the coverage. This bill also requires the department of insurance to submit a request for information and a request for proposals concerning the establishment and operation of an all payer claims database, which will receive and contain information on claims paid by insurers, health maintenance organizations, pharmacy benefit managers, and other payers.	Sen. Ed Charbonneau (R)
KY	HB 73	Referred to House Banking and Insurance Committee	APCD	This measure requires the commissioner of the Department of Insurance to appoint an advisor committee to create a framework and implementation plan for an all-payer claims database to facilitate the reporting of health care and quality data.	Rep. Robert Wiederstein (D)
LA	HB 553	Referred to House Health and Welfare Committee	Telehealth	This measure allows Medicaid to cover remote patient monitoring reimbursement to Louisiana-based facilities. The originating site is eligible to receive a facility fee but a distant site cannot receive a facility fee.	Rep. Raymond Crews (R)
MA	S 659/S 2364	Referred to Senate Ways and Means Committee	Transparency	This measure is a comprehensive bill focused on protecting patient access to necessary medical treatments. It includes protections against balance billing as well as requirements for increased health care price transparency for consumers, and prohibitions on charging state employee health plans a facility fee for a current procedural terminology evaluation and management code. A hospital, health system, or hospital-based facility shall not charge, bill, or collect a facility fee for services utilizing a current procedural terminology evaluation and management code if the service was provided by a hospital-based facility located off a campus unless the facility fee was charged, billed or collected by the hospital-based facility on or before July 1, 2017. It also requires each hospital and health care provider that is a member of a provider organization to establish a written financial assistance policy according to specific guidelines outlined in this measure.	Sen. James Welch (D)/Senate Financial Services Committee
MA	H 1164/S 718	Moved to 2021 Session	Transparency	This measure requires the Health Policy Commission (HPC) to hold an annual public hearing based on the report submitted by the Center for Health Information Analysis (CHIA). The hearing must examine health care provider, provider organization, and private and public payer costs, prices, and weighted average payer rates. A weighted average payer rate (WAPR) is defined as a measure by which a sum of the inpatient revenue per discharge and outpatient revenue per visit is separately calculated for commercial insurers, Medicare, and Medicaid. A weighted average of the three resulting values is derived, with the net patient service revenue-based payer mix of the three payers serving as weights.	Rep. Kevin Honan (D)/Sen. Michael Rush (D)
MA	S 693	Moved to 2021 Session	Transparency	This measure requires the Center for Health Information Analysis to identify hospitals that are in financial distress, including hospitals that are at risk of closing or discontinuing health services. The center must report a list of at-risk hospitals to the secretary of Health and Human Services, commissioner of Public Health, and the executive director of the Health Policy Commission. This bill also requires health facilities to provide 90-day notice prior to the discontinuation of an essential health service and a 120-day notice prior to the closure of a hospital.	Sen. John Keenan (D)
MA	H 1045	Referred to House Financial Services Committee	Transparency	This measure requires a health care entity to disclose to a patient, prior to a non-emergency admission or procedure, the allowed amount for the procedure including facility fees. It also requires carriers to establish an interactive mechanism for enrollees to request and obtain information on the payments made by the carrier to providers for health care services. A carrier must develop and implement a program that provides incentives for enrollees in a health plan who elect to receive shoppable health care services.	Rep. Ronald Mariano (D)
MA	H 1046	Passed House Financial Services Committee and Referred to Joint Health Care Financing Committee	Facility Fees	This measure requires that a hospital, hospital-based facility, or a health care provider that charges or bills a facility fee for services provide any patient receiving such a service with written notice of the fee. If a hospital or health system designates a location as a hospital-based facility, the facility must clearly identify the facility as being hospital-based, including by stating the name of the hospital or health system in the facility's signage, marketing materials, Internet websites and stationery. If a hospital-based facility charges a facility fee, notice must be posted informing patients that a patient may incur additional financial liability due to the hospital-based facility's status.	Rep. Ronald Mariano (D)

State	Bill	Status	Category	Summary	Sponsor
MA	S 700	Moved to 2021 session	Facility Fees	This measure requires that prior to the delivery of nonemergency services, a hospital-based facility that charges or bills a facility fee for services shall inform the patient that: 1) it is licensed as part of the hospital and the patient may receive a separate charge that is in addition to and separate from the professional fee charged by the provider; 2) the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and 3) information on how the patient can obtain financial liability for the known services through the hospital or the patient's insurance carrier, along with information that the actual liability may change depending on the actual services provided. If a hospital or health system designates a location as a hospital-based facility, the facility shall clearly identify the facility as being hospital-based, including by stating the name of the hospital or health system in the facility's signage, marketing materials, Internet websites and stationery and by posting notices in designated locations accessible to and visible by patients in a manner prescribed by the commissioner.	Sen. Jason Lewis (D)
MA	H 4134	Referred to the Joint Financial Services Committee	Cost Benchmark	This measure, among other things, requires payers and providers to increase combined expenditures on primary care and behavioral health by 30% over three years. Providers and insurers will be required to report their progress on an annual basis through the Center for Health Information Analysis (CHIA) and Health Policy Commission's (HPC). If the target is not achieved, providers and insurers will be referred by CHIA to the HPC and may be subject to a performance improvement plan that may require them to identify strategies and opportunities to increase investments in primary care and behavioral health. It also prohibits surprise medical billing for emergency and unplanned services rendered by an out-of-network provider at an in-network facility, expands access to telemedicine, and adds Massachusetts to the Nurse Licensure Compact. This bill also directs the Health Policy Commission to identify services on which there should be limitations on facility fees. It prohibits a provider from charging, billing, or collecting a facility fee for services provided on a hospital's campus, services at a facility that includes an emergency department, or services provided at a satellite emergency facility.	Gov. Charlie Baker
MA	H 975/S 655	Ruled ought NOT to pass by the Joint Financial Services Committee and placed in the Orders of the Day for the next session	Cost Benchmark	This measure sets certain standards for ambulance payments and requires that the rate patients pay reflect the municipality where the patient is transported from. An ambulance service provider receiving payment for an ambulance service shall be deemed to have been paid in full for the ambulance service provided to the insured, and shall have no further right or recourse to further bill the insured for said ambulance service with the exception of coinsurance, co-payments, or deductibles for which the insured is responsible under the insured's insurance policy or insurance contract. It requires municipalities to report their municipally established ambulance rates to the Center for Health Information Analysis to be included in its Transparency Initiative. Municipalities shall not increase their municipally established ambulance rates by a percentage that exceeds the current Health Care Cost Growth Benchmark set by the Health Policy Commission unless approved by the secretary of health and human services. A municipality may appeal to the secretary for a municipally established ambulance rate increase that is in excess of the current Health Care Cost Benchmark. There shall be an ambulance service advisory council to advise the secretary on such requests	Rep. Carole Fiola (D)/Sen. Walter Timilty (D)
MA	H 1054	Referred to the Joint Financial Services Committee	Cost Benchmark	This measure sets certain standards for ambulance payments and requires that the rates patients pay reflect the municipality where the patient is transported from. An ambulance service provider receiving payment for an ambulance service shall be deemed to have been paid in full for the ambulance service provided to the insured, and shall have no further right or recourse to further bill the insured for said ambulance service with the exception of coinsurance, co-payments, or deductibles for which the insured is responsible under the insured's insurance policy or insurance contract. It requires municipalities to report their municipally established ambulance rates to Center for Health Information Analysis to be included in its Transparency Initiative. Municipalities shall not increase their municipally established ambulance rates by a percentage that exceeds the current Health Care Cost Growth Benchmark set by the Health Policy Commission unless approved by the secretary of health and human services. A municipality may appeal to the secretary for a municipally established ambulance rate increase that is in excess of the current Health Care Cost Benchmark. There shall be an ambulance service advisory council to advise the secretary on such requests.	Rep. Paul McMurtry (D)

State	Bill	Status	Category	Summary	Sponsor
MA	H 1186	Referred to the Joint Financial Services Committee	Cost Benchmark	This measure requires providers or provider organizations to submit notice to the Health Policy Commission (HPC) before making any material change to its operation or governance structure, such as a corporate merger, acquisition, or affiliation of a provider or provider organization and a carrier. Within 30 days of notice, the Health Policy Commission shall conduct a preliminary review to determine whether a material change is likely to result in a significant impact on the state's ability to meet the health care cost growth benchmark. If the HPC finds it is likely to have a significant impact, then the HPC shall conduct a cost and market impact review. A cost and market review may examine factors including but not limited to the provider organization's size and market share, total medical expense, quality of services provided, provider costs and cost trends, provider organization's impact on competing options for delivery, and the methods used to attract patients and providers as well as the methods used to direct patients to the lowest-cost setting. The HPC may deny the providers' request for material change based on this review.	Rep. David Nangle (D)
MA	H 1124	Referred to the Joint Financial Services Committee	Cost Benchmark	This measure strengthens the process for the Health Policy Commission to establish Performance Improvement Plans for requiring health care entities that are found to exceed the health care cost growth benchmark in the previous year to file performance improvement plans.	Rep. James Arciero (D)
MA	H 1174/S 673	Moved to 2021 session	Other	This measure creates the Community Hospital and Health Center Reinvestment Trust Fund to provide annual financial support to eligible acute-care hospitals and community health centers. The secretary of the Department of Health and Human Services will administer the fund. An eligible hospital must be an acute-care hospital, either a "high public payer facility" or a hospital with an average relative price below the statewide average price.	Rep. Elizabeth Malia (D)/Sen. Julian Cyr (D)
MA	H 2001	Referred to the Joint Committee on Public Health	Other	This measure establishes a health planning council within the Health Policy Commission to make recommendations to maintain and improve quality of care, support the efforts to meet the cost-growth benchmark, and support innovated delivery and payment reform, among other priorities.	Rep. Jeffrey Roy (D)
MD	SB 42	Enacted into law	Transparency	This measure alters the information the Health Services Cost Review Commission must include in its annual report. The Commission must include, among other things: outpatient hospital per capita cost growth for all payers and annual progress toward achieving the state's financial targets established by the all-payer model.	Finance Committee
MD	HB 1169/SB 774	Enacted into law	Community Benefit	This measure directs the Health Service Cost Review Commission to establish the Community Benefit Reporting Workgroup composed of individuals and stakeholders with knowledge of, and impacted by, hospital community benefit spending. Nonprofit hospitals will be required to submit an annual report on community benefit spending. The commission, in consultation with non-profit hospital representatives, will adopt regulations which establish the standard reporting format, the reporting deadline, and the period of time the report must cover. The workgroup's recommendations, to be adopted into regulations by the commission, will include a requirement that hospitals submit an annual report to the commission detailing the community benefits provided by the hospital during the preceding year, including: hospital activities to address identified community health needs, the cost of each activity, and a list of tax exemptions the hospital claimed, among other details. The commission will establish a method through which state and local governing bodies are made aware of the meetings of the Community Benefit Reporting Workgroup. Additionally, the commission will compile these reports into a publicly available Nonprofit Hospital Community Health Benefit Report which will be submitted to the House Health and Government Operations and Senate Finance committees.	Del. Erik Barron (D)
MD	HB 915/SB 632	Enacted into law	Facility Fees	This measure requires that if a hospital charges an outpatient facility fee, the hospital provide the patient with a written notice, separate from any other forms or notices. The patient must sign this notice before receiving services. The notice, a full template of which is available in the measure, includes the address and contact information of a "no facility fee location" where the patient can see a provider at a location which does not charge a facility fee. The hospital must provide a range of potential facility fees based on typical or average facility fees for the same or similar appointments. Annually, each hospital will report to the Health Services Cost Review Commission a list of the hospital-based, rate-regulated outpatient services provided by the hospital. The Health Services Cost Review Commission will publish this information online and provide it to the Maryland Insurance Administration and the Health Education and Advocacy Unit in the Office of the Attorney General.	Del. Robbyn Lewis (D)/Sen. Delores Goodwin Kelley (D)

State	Bill	Status	Category	Summary	Sponsor
MD	HB 1081/SB 873	Died in House Health and Government Operations Committee & Withdrawn/Died in Senate Finance Committee & Withdrawn	Other	This measure requires hospitals to report to the Health Service Cost Review Commission an annual report on the hospital's policy on medical debt. It must include the total number of patients by race or ethnicity, gender, and zip code, that the hospital or an outside collection agency have filed an action to collect a debt and the total number of patients that the hospital has not reported or classified a bad debt. Hospitals must also report the total dollar amount of the costs of hospital services provided to the patients but not collected. The commission is required to provide a mechanism for patients to modify the terms of a payment plan. This bill also prohibits hospitals from collecting debt from a patient who is eligible for free or reduced-cost care under the hospital's financial assistance policy. It also lays out restrictions for interest fees on a hospital bill and sets restrictions on hospitals' debt collection practices.	Del. Lorig Charkoudian (D)/Sen. Brian Feldman (D)
ME	LD 2110	Died in Senate	Cost Benchmark	This measure establishes the Maine Commission on Affordable Health Care, an independent agency to oversee Maine's health care delivery and payment system. The commission is established to set health care cost growth and quality goals, enhance transparency of provider organizations, monitor the adoption of alternative payment methods, foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care, monitor and review the impact of changes in the health care market, protect patient access to necessary health care services, set health care spending targets for public payers including separate targets for prescription drug spending, and serve as a resource for consumers experiencing problems accessing health coverage and to resolve consumer complaints in cooperation with the Consumer Health Care Division.	Sen. Troy Jackson (D)
MN	HF 3824	Referred to House Health and Human Services Policy Committee	APCD	This measure changes Minnesota's all-payer claims database (APCD) reporting requirements to mandate that health plans submit data on a monthly basis. It also allows the insurance commissioner to publicize data that identifies individual hospitals, clinics, or other providers. The insurance commissioner must also develop recommendations to allow outside organizations to access the data in the APCD.	Rep. Steve Elkins (D)
MN	HF 4644	Referred to House Health and Human Services Finance Division	APCD	This measure directs the commissioner to consult with Minnesota's tribal nations and other communities on how to ensure all-payer claims data addresses their health care challenges. It also allows the commissioner to grant access to the data to qualified users who demonstrate that a research proposal has the potential to improve health, health care, or public health outcomes. The commissioner will convene a data access advisory group of specified public health and health care appointees to assist with the review and administration of these research proposals.	Rep. Tina Liebling (D)
MN	HF 2517	Referred to House Health and Human Services Policy	Transparency	This measure requires hospitals, including hospitals designated as critical access hospitals, to disclose to each discharged patient within a week of discharge an itemized description of billed charges for medical services and goods the patient received during the hospital stay. The itemized description of billed charges may not use terms that are indecipherable or are described as "miscellaneous charges" or "supply charges." The hospital may not add a processing charge for the itemized billing.	Rep. Jeremy Munson (R)
MN	HF 2715/SF13	Signed by Governor	Transparency	This measure requires hospitals, including hospitals designated as critical access hospitals, to disclose to each discharged patient within a week of discharge an itemized description of billed charges for medical services and goods the patient received during the hospital stay. The itemized description of billed charges may not use terms that are indecipherable or are described as "miscellaneous charges" or "supply charges." The hospital may not add a processing charge for the itemized billing.	Rep. Hunter Cantrell (D)/Sen. Rich Draheim (R)
MN	SF 3	Referred to Senate Commerce and Consumer Protection Finance and Policy Committee	Transparency	This measure requires health plans to offer a shared savings incentive program to its enrollees. Plans must deposit the incentive payment into the enrollees' accounts for an enrollee to use towards copays, coinsurance, or deductibles. The enrollee may withdraw the funds if they have met their out-of-pocket maximum. This bill also requires the insurance commissioner to develop a web-based interactive system for consumers to use to compare provider average charges for health care services by procedure code.	Sen. Rich Draheim (R)

State	Bill	Status	Category	Summary	Sponsor
MN	HF 4547	Referred to House Commerce Committee	Transparency	This measures allows a patient or enrollee to request in writing from a provider or health plan company an itemized bill that includes all charges for which the provider bills the patient for services provided. A health care provider must establish a Medicare percent that the provider is willing to accept as payment in full for health care services provided by that provider. A provider must provide notice to patients and the public of the provider's Medicare percent by posting information describing the Medicare percent and specifying the provider's Medicare percent in a prominent, clearly visible location at or near the provider's reception desk, registration desk, or patient check-in area; posting information describing the Medicare percent and specifying the provider's Medicare percent on the provider's public website; and including information describing the Medicare percent and specifying the provider's Medicare percent on any document related to provider payments that the provider requires a patient or patient's representative to sign. An individual health care provider employed by, affiliated with, or under contract with a hospital, health care facility, or medical clinic shall not be reimbursed at an amount greater than the amount of the hospital's or clinic's Medicare percent. Before providing health care services to a patient, a health care provider must provide the patient or patient's representative with a Medicare percent disclosure form describing the Medicare percent; and obtain the signature of the patient or patient's representative on a copy of the form retained by the provider. Under this measure, when a health care provider transmits a bill to a patient, the bill must specify for the health care services provided the dollar amount the provider is willing to accept as payment in full; the Medicare-allowable fee-for-service payment rate; and the provider's Medicare percent. For patients covered by a health plan, a provider must also include a copy of the Medicare percent disclosure form signed by the patient or the patient's representative.	
MN	HF 270/SF 1524	Referred to House Health and Human Services Policy Committee/Referred to Senate Health and Human Services Finance and Policy Committee	Other	This measure establishes the 11-member Minnesota Health Policy Commission to, among other duties, compare the state's commercial health care costs and public health care spending in other states; identify factors that influence and contribute to its ranking for commercial health care costs, and monitor efforts to reform health care delivery and payment, particularly those with the goal to reduce per capita cost of health care and lower the rate of growth in commercial health care costs.	Rep. Joe Schomacker (R)/Sen. Michelle Benson (R)
MO	SB 904	Referred to Senate Insurance and Banking Committee	Facility Fees	This measure prohibits a provider-based facility from charging, billing, or collecting a facility fee for services rendered. The patient shall not be responsible for such charge unless Medicare is the primary payer for such patient and the facility is allowed to charge the fee under federal law or the patient is covered by MO HealthNet and MO HealthNet allows the facility to charge for the fee.	Sen. Paul Wieland (R)
MO	HB 2311	Referred to House Insurance Policy Committee	Facility Fees	This measure prohibits a provider-based facility from charging, billing, or collecting a facility fee for services rendered. The patient shall not be responsible for such charge unless Medicare is the primary payer for such patient and the facility is allowed to charge the fee under federal law or the patient is covered by Medicaid and Medicaid allows the facility to charge the fee.	Rep. Mike Haffner (R)
NC	SB 361	Signed by Governor	Telehealth	This measure directs the Department of Health and Human Services to update the North Carolina Medicaid and NC Health Choice Clinical Coverage Policy. A referring provider who is eligible to bill for facility fees and a receiving provider who is eligible to bill for facility would be allowed to bill for facility fees related to the provision of telemedicine or telepsychiatry on the same date of service.	Sen. Joyce Krawiec (R)
NH	SB 555	Died	Telehealth	This measure requires an insurer offering a health plan in the state to provide coverage and reimbursement of health care services provided through telemedicine on the same basis as the insurer provides coverage and reimbursement for health care services provided in person. An insurer must provide a reasonable facility fee to an originating site operated by a health care provider or a licensed health care facility if the health care provider or licensed health care facility is authorized to bill the insurer directly for health care services. The combined amount of reimbursement that a health benefit plan allows for the compensation to the distant site and the originating site cannot be less than the total amount allowed for health care services provided in person.	Sen. Jay Kahn (D)

State	Bill	Status	Category	Summary	Sponsor
NJ	S 1102	Referred to Senate Community and Urban Affairs Committee	Community Benefit	This measure amends the tax code for certain nonprofit acute-care hospitals and requires the hospitals to enter into payment in lieu of taxation agreement in certain circumstances. If the average of the community benefit expense percentages of total expense reported by a qualified nonprofit acute-care hospital is 5% or greater, but not greater than 8%, and the average of the combined community benefit expense and community building activities percentages of total expense reported on those filings is less than 10%, the owner of the hospital shall enter into a payment in lieu of taxation agreement with the municipality in which the hospital is located for the current tax year. If it is greater than 8% or the average of the of the combined community benefit expense and community building activities percentages of total expense reported on those filings is 10% or greater, the owner of the hospital may enter into a voluntary payment in lieu of taxation agreement with the municipality in which the hospital is located for the current tax year. If a nonprofit acute-care hospital does not meet the requirements of a qualified nonprofit acute-care hospital and is not exempt from taxation, the municipality in which the hospital is located may enter into a payment in lieu of taxation agreement with the owner of the hospital, and forgo the collection of property taxes with respect to that hospital.	Sen. Joseph Vitale (D)
NJ	A 1088	Referred to Assembly Health Committee	Other	This measure exempts certain specialty hospitals from paying a 0.53% assessment towards the Health Care Subsidy Fund.	Asm. Carol Murphy (D)
NY	AB 8639/SB 6757	Referred to Assembly Health Committee/Referred to Senate Health Committee	Transparency	This measure requires a general hospital to provide the patient a consolidated itemized statement or a bill detailing in plain language, comprehensible to an ordinary layperson, the specific nature of charges or expenses incurred by the patient. It requires each itemized statement to comply with standards in this measure. It also prohibits licensed health care professionals from billing facility fees, except those that are licensed under a residential health care facility or health under the education law. It also requires a uniform patient financial liability form developed by the Commissioner of Health.	Asm. Richard Gottfried (D)/Sen. Gustavo Rivera (D)
NY	AB 543/SB 5479	Referred to Assembly Health Committee/Referred to Senate Health Committee	Study	This measure establishes an office-based surgery work group to review and make recommendations on trends in reimbursement rates for outpatient surgical care, regional differences regarding access and costs, the impact of rates of reimbursement across settings on consumers, and the impact of rates of reimbursement on health premiums.	Asm. Kevin Cahill (D)/Sen. Gustavo Rivera (D)
NY	SB 8076	Referred to Senate Health Committee	Other	This measure requires hospitals and health care professionals to use the uniform patient financial liability form developed by the commissioner. The standardized form will disclose to patients whether their care is in-network or out-of-network, whether it is a covered benefit under the patient insurance contract, and the exact amount of the patient's projected financial liability. This bill also requires hospitals to use a uniform assistance form policy developed by the commissioner. Immigration status may not be an eligibility criterion.	Sen. Gustavo Rivera (D)
NY	SB 3462	Referred to Senate Health Committee	Other	This measure allows health care providers in a certain geographic area to collectively negotiate for terms and conditions in a contract with a health plan if a health plan has significant market share. Before engaging in collective negotiation, the health care provider representative must file with the commissioner.	Sen. Gustavo Rivera (D)
OH	SB 97	Passed House Health Committee	Transparency	This measure requires hospitals, on the request of a patient, to provide a reasonable, good faith estimates of the cost of each health care service a patient has scheduled. It must include the amount the patient or party responsible for paying for the patient's care will be required to pay. This bill also requires hospitals to post online a list of the hospital's standard charges for items and services provided by the hospital.	Sen. Stephen Huffman (R)
OH	HB 679	Referred to Senate Insurance and Financial Institutions Committee	Telehealth	This measure prohibits a health care professional providing telehealth services from charging a health plan issuer covering telehealth services a facility fee, an origination fee, a fee associated with the administrative costs incurred in providing telehealth services, or any fee associated with the cost of the equipment used to provide telehealth services. A health care professional providing telehealth services is not required to receive a patient's consent before billing for the cost of providing the services.	Rep. Mark Frazier (R)
OK	HB 3029	Died in House	Transparency	This measure requires a health care provider to make available to the public via a website the prices of the 20 most common health care services. It also requires health care facilities to make available the prices for the 20 most used diagnosis-related group codes and the 20 most used outpatient health care service procedure codes.	Rep. Carol Bush (R)
OK	SB 1824	Died in Senate Retirement and Insurance Committee	Transparency	This measure requires plans to establish a program in which employees are incentivized to shop for and choose low-cost, high-quality participating providers for comparable health care services. Incentives could include a reduction of premiums, copayments, or deductibles. This bill also requires plans to maintain an interactive website for employees to obtain information on the estimated cost of health care services.	Sen. Greg McCortney (R)

State	Bill	Status	Category	Summary	Sponsor
OK	SB 1575	Died in Senate	Transparency	This measure requires plans to establish a program in which enrollees are incentivized to shop, before and after their out-of-pocket limit has been met, for lower-cost health care services by a nonparticipating provider that are comparable to participating provider services. Carriers must also establish an interactive mechanism for enrollees to request and obtain cost estimates.	Sen. Kim David (R)
OK	HB 3489/SB 218	Died in House/Referred to Senate Retirement and Insurance Committee	Transparency	This measure requires plans to establish a program in which enrollees are incentivized to shop, before and after their out-of-pocket limit has been met, for lower-cost health care services by a nonparticipating provider that are comparable to participating provider services. Carriers must also establish an interactive mechanism for enrollees to request and obtain cost estimates.	Rep. Chris Sneed/Sen. Dewayne Pemberton (R)
OK	HB 2780	Passed House Insurance Committee	Transparency	This measure requires health care plans to establish a program in which enrollees are directly incentivized to shop, before and after their out-of-pocket limit has been met, for lower-cost participating health care providers or entities for comparable health care services. Incentives must be first applied toward copayments, cost-sharing, or deductibles.	Rep Jim Olsen (R)
OK	HB 3290	Referred to Senate Retirement and Insurance Committee, then to Senate Appropriations Committee	Transparency	This measure requires carriers to develop and implement a program that provides incentives for enrollees who elect to receive a comparable health care service that charges less than the average allowed amount paid by that carrier to network providers for that comparable health care service. The carrier must provide at least 50% of the carrier's saved costs for each service or category of comparable health service.	Rep. Zack Taylor (R)
OR	HB 4029	Died in Senate Health Care Committee	Other	This measure prohibits nonprofit hospitals from requiring a patient to apply for medical assistance before the patient is screened for or provided financial assistance.	House Interim Committee on Health Care
PA	HB 197	Referred to House Health Committee	Transparency	This measure requires health care providers to publish the cost of health care procedures.	Rep. Greg Rothman (R)
PA	HB 2476	Passed House Health Committee	Transparency	This measure provides for the establishment of value-based models relating to the Hospital Outcomes Program, value-based models relating to the Managed Care Organization Outcomes Program, and managed care organization Medicaid contracts.	Rep. Seth Grove (R)
RI	H 7309/S 2227	Referred to House Health, Education, and Welfare Committee/Referred to Senate Health and Human Services Committee	Transparency	This measure expands the Health Services Council, the body responsible for licensing health care facilities, from 12 to 24 members, and adds a penalty for a failure to disclose or intentionally misrepresenting information submitted to state regulators.	Rep. David Bennett (D)/Sen. Dawn Euer (D)
RI	H 7171	Sub A signed by governor, which does not include Article 20 which contains the provisions described.	Cost Benchmark	This measure creates the Health Spending Transparency and Containment Program to utilize claims data to help reduce health care costs. The program will maintain an annual Health Care Cost Growth Target that will be used as a voluntary benchmark to measure Rhode Island health care spending performance. The program will determine what factors are causing increasing health spending and create actionable analysis to address these factors. The program will provide an annual report to the governor and general assembly.	Rep. Marvin Abney (D)
SC	S 991	Referred to Banking and Insurance Committee	Transparency	This measure requires a carrier to develop and implement a program that provides incentives for the enrollees who elect to receive a shoppable health care service from providers that charge less than the average price paid by the carrier.	Sen. Wes Climer (R)
TN	HB 278/SB 322	Referred to House Finance, Ways, & Means Committee/Deferred to Summer Study	Transparency	This measure requires the Department of Commerce and Insurance to enter into a memorandum of understanding for collaboration in developing a comprehensive health care information system. The department will make available to the public a public use data set for the purposes of facilitating transparency in health care costs.	Rep. Martin Daniel (R)/Sen. Shane Reeves (R)
TN	HB 753/SB 1169	Died in House Finance, Ways and Means Committee / Died in Senate Commerce and Labor Committee	Telehealth	This measure requires insurers to reimburse healthcare service providers for a telehealth originating site facility fee.	Rep. Robin Smith (R)/Sen. Art Swann (R)
TN	HB 2350/SB 2312	Died in House / Died in Senate	Other	This measure amends the state's certificate-of-need process.	Rep. Robin Smith (R)/Sen. Todd Gardenheire (R)
TN	HB 1085	Died in House Finance, Ways, and Means Committee	Other	This measure would repeal the state's certificate-of-need process.	Rep. Martin Daniel (R)
VA	HB 30/SB 30	Signed by Governor	Telehealth	This measure directs the Department of Medical Assistance Services to increase the telehealth originating site facility fee to 100% of the Medicare rate and reflect changes annually based on any changes in the Medicare rate. Federally Qualified Health Centers and Rural Health Centers are exempt from this reimbursement change.	Rep. Luke Torian (D)/Sen. Thomas Norment

State	Bill	Status	Category	Summary	Sponsor
VT	H 795	Signed by Governor	Transparency	This measure directs the Green Mountain Care Board to use information from Vermont's all-payer claims database and hospitals to develop and maintain an online, public price transparency dashboard for consumers to compare health care prices for certain health care services across the state. This dashboard will become available for public use no later than Feb. 12, 2022. The board shall consider ways to increase the financial sustainability of Vermont hospitals and identify processes for improving provider sustainability and increasing equity in reimbursement amounts among providers. Upon request, insurers shall provide to the board detailed information about the insurer's payments to specific providers. The board may disclose or release this information publicly if doing so would not disclose confidential business information or trade secrets. This measure authorizes the Department of Financial Regulation to adopt emergency rules to address specified health insurance coverage issues through June 30, 2021.	Rep. Lucy Rogers (D)
VT	H 787/S 247	Referred to House Health Care Committee/Referred to Senate Health & Welfare Committee	Transparency	This measure requires hospitals to report to the Green Mountain Care Board the total amount of savings realized from the 340B drug pricing program and how a hospital used or plans to use those savings.	Rep. Sarah Copeland Hanzas (D)/Sen. Christopher Pearson (D)
VT	H 727	Referred to House Health Care Committee	Facility Fees	This measure requires a health insurance plan to provide the same reimbursement amounts to licensed physical therapists for physical therapy services associated with the same billing codes regardless of the setting in which the physical therapy services were provided.	Rep. Carol Ode (D)
VT	S 290	Referred to Senate Health and Welfare Committee	Payments	This measure proposes to: create additional reporting, certification, and budget requirements for accountable care organizations; direct hospitals to report certain rate increases to the Green Mountain Care Board; and impose new requirements on contracting between health plans and health care providers. It requires the Green Mountain Care Board to review annually the budgets of designated and specialized service agencies and preferred provider organizations. It also require the board to begin exercising its rate-setting authority and to establish site-neutral reimbursement amounts, and direct the board to review and approve contracts between health plans and health care providers	Sen. Virginia Lyons (D)
WA	HB 2036/SB 6594	Died in House Rules Committee/Died in Senate Health & Long Term Care committee	Transparency	This measure amends the hospital financial reporting requirements for hospitals in Washington State. Hospitals must also report revenus, expenses, contractual allowances, charity care, bad debt, and total units of inpatient and outpatient services. When reporting revenues, hospitals must include an addendum with a description of the services provided in exchange for income or revenue for any service that generates more than $50,000 cumulatively during the reporting period. When reporting expenses, hospitals must report expenses defined by the department and, for any expenses that do not meet a defined category, the hospital must include an addendum report with a description of the expenses and for any expense that costs more than $50,000 cumulatively during the reporting period. In addition, the entity must report any financial exchanges between the entity and each health care facility component or service, or between health care facility components and services, with an explanation of the nature of each exchange over $50,000, and the total number of full-time equivalents at each health care facility component or service. Each hospital must make public an addendum that details information about activities identified as community health improvement services, specifying the type of activity, the method in which each type of activity was provided, the resources used to provide the activity, how each activity may correspond to follow-up services offered by the hospital, the cost of providing each type of activity, and any materials provided to activity participants. This bill also requires hospitals to report on debt collection practices and to report any of the entities it contracts with to collect debt.	Rep. Nicole Macri (D)/Sen. Steve Conway (D)
WA	HB 2770/SB 5385	Signed by Governor	Telehealth	This measure requires health carriers to reimburse a provider for a health care service provided to a covered person through telemedicine at the same rate as if the health care service was provided in person by the provider. Hospitals, hospital systems, telemedicine companies, and provider groups consisting of 11 or more providers may elect to negotiate a reimbursement rate for telemedicine services that differs from the reimbursement rate for in-person services. Reimbursement for facility fees must be subject to a negotiated agreement between the originating site and the health plan.	Rep. Marcus Riccelli (D)/Sen. Randi Becker (R)

State	Bill	Status	Category	Summary	Sponsor
WA	HB 2457	Signed by Governor	Cost Benchmark	This measure requires the Washington Health Care Authority to establish the Health Care Cost Transparency Board to analyze total health care expenditures, identify trends in health care cost growth, and establish a health care cost growth benchmark. The board shall establish an advisory committee on data issues and an advisory committee of health care providers and health plans. The board will determine the types and sources of data necessary to calculate the benchmark and the method for data collection. The board may contract with a private, non-profit entity to administer the board and carry out its responsibilities.	Rep. Eileen Cody (D)
WV	HB 3019	Died in House Health and Human Resources Committee	Transparency	This measure requires the Bureau for Public Health to publish compilations or reports that compare and identify health care facilities and health care plans. The bureau must include a section or a separate report with comparative information on the cost and quality of routine preventive care and treatment of diabetes, heart disease, and other illnesses. This bill also allows the bureau to create a health care price transparency tool to present price information for consumers through a user-friendly online portal.	Del. Joseph Jeffries (R)
WV	HB 4003	Signed by Governor	Telehealth	This measure requires an insurer who issues or renews a policy after July 1, 2020, to provide coverage of health care services provided through telehealth services if those same services are covered through face-to-face consultation by the policy. An originating site my charge an insurer a site fee.	Del. Zack Maynard (R)