PIONEER
HEALTH

# Status of Healthcare Price Transparency across the United States

By Caterina DiBiase, Lauren Corvese, Scott Haller,
Barbara Anthony, Josh Archambault, and Seher Chowdhury

WHITE PAPER
No. 206 | May 2020

PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

## Pioneer's Mission

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to improve the quality of life in Massachusetts through civic discourse and intellectually rigorous, data-driven public policy solutions based on free market principles, individual liberty and responsibility, and the ideal of effective, limited and accountable government.

PIONEER HEALTH

**This paper is a publication of Pioneer Health,** which seeks to refocus the Massachusetts conversation about health care costs away from government-imposed interventions, toward market-based reforms. Current initiatives include driving public discourse on Medicaid; presenting a strong consumer perspective as the state considers a dramatic overhaul of the health care payment process; and supporting thoughtful tort reforms.

PIONEER PUBLIC

**Pioneer Public** seeks limited, accountable government by promoting competitive delivery of public services, elimination of unnecessary regulation, and a focus on core government functions. Current initiatives promote reform of how the state builds, manages, repairs and finances its transportation assets as well as public employee benefit reform.

PIONEER EDUCATION

**Pioneer Education** seeks to increase the education options available to parents and students, drive system-wide reform, and ensure accountability in public education. The Center's work builds on Pioneer's legacy as a recognized leader in the charter public school movement, and as a champion of greater academic rigor in Massachusetts' elementary and secondary schools. Current initiatives promote choice and competition, school-based management, and enhanced academic performance in public schools.

PIONEER OPPORTUNITY

**Pioneer Opportunity** seeks to keep Massachusetts competitive by promoting a healthy business climate, transparent regulation, small business creation in urban areas and sound environmental and development policy. Current initiatives promote market reforms to increase the supply of affordable housing, reduce the cost of doing business, and revitalize urban areas.

Pioneer Institute is a tax-exempt 501(c)3 organization funded through the donations of individuals, foundations and businesses committed to the principles Pioneer espouses. To ensure its independence, Pioneer does not accept government grants.

# Table of Contents



## Executive Summary

This paper describes the scope of healthcare price transparency laws in all 50 states. Each law was evaluated on whether it required information for the out-of-pocket costs of healthcare services to consumers—whether insured or uninsured. We looked at whether such laws applied to hospitals and/or physicians, as well as insurance carriers. We used a three-tiered system, plus other categories for special cases, and placed each state in its relevant tier.

Overall, we found robust price transparency laws are not widespread in the United States. Only six states achieved our top tier designations, Tier 1 and 1A. Eleven earned our Tier 2 and 2A ranking, and thirty-three were left in the bottom tier, Tier 3.

As a result of our research, we recommend first, that states conduct a review of their current price transparency laws, or lack thereof, and consider initiating processes that would allow patients to see real prices that they would pay before they receive a service or procedure in all non-emergency cases. Admittedly, this may not be a simple task because healthcare pricing is complicated by several variables. First, there is the "list price" or "charges" which hospitals ascribe to each and every procedure or service provided. Second, there is the price that insurance companies pay to hospitals for each procedure or service under contract with the hospital. Finally, there is the amount a consumer must pay to the hospital or doctor.

This last amount is related to the patient's "deductible" and the deductible can range anywhere from zero dollars to over $7,000 for an individual. Except for certain types of preventative care, a consumer's insurance coverage cannot be used until the consumer's deductible has been met. For example, a consumer may have an annual deductible of $1500. Assume that same consumer needs an MRI of his right knee and the imaging center or hospital charges a fee of $700 for such an MRI. In this example, assuming no discounts apply, the consumer would have to pay $700 to the imaging center and the consumer would have a remaining deductible of $800.

As can be seen from the example above, if a consumer is uninsured, he or she would have to pay whatever the facility charges for people who pay themselves. Sometimes, there are cash discounts for self-paying patients. A hospital or doctor may also charge an insured patient the amount the insurance company would pay the hospital or doctor if that consumer had reached his deductible. This amount will always be less than the so-called "list price" or "charges."

As such, isolating the price a consumer must pay can be a complicated undertaking. We believe, however, that the price consumers pay for healthcare is one of their biggest concerns. A recent Massachusetts survey of insured workers showed that 70 percent wanted to know the price they would have to pay for a procedure ahead of time.[1] This same survey showed, however, that providing tools and information to consumers about out-of-pocket costs is only the beginning of the process. The survey showed that even when consumers have access to price information, most do not use it to compare prices for shoppable procedures.[2] This means that much education, outreach and very consumer-friendly technologies are necessary to foster searches for transparent healthcare prices.

Second, we recommend that states evaluate the benefits and limitations of a state-sponsored All Payer Claims Database (APCD). A small number of states have agencies that collect de-identified data on all claims paid by insurance companies. These data can then be used to provide various types of pricing information for both consumers and researchers while also giving public and private entities the data to create cost estimator web tools

Lastly, states should work with providers, payers, employers, and transparency advocates to create ways to educate individuals about the pricing tools and resources that are available to them. Through these recommendations, price transparency could be more accessible and available to individuals in every state. In addition, states should engage carriers and employers to offer rewards or/and incentives to consumers and employees for choosing high-value/lower-cost providers.[3] These recommendations that advocate more price transparency acknowledge that its success depends on numerous factors:

- Political and business leadership
- Ease of access to healthcare prices
- Educating consumers and employees
- Providing incentives that will reward consumers for choosing high value/lower cost providers

## Introduction

In free economies, it seems natural for consumers to have their pick of products and services. For example, it's easy to compare the price of different brands or products at the grocery store, as price and ingredient information are readily transparent. If consumers want to know more, they can go online and look up product or retailer reviews.

When consumers buy plane tickets, there are numerous online platforms for comparing prices. We can see how much one flight that includes two checked bags costs compared to a different flight that only allows a single carry-on. Consumers can consider the benefits and drawbacks of each flight by viewing flight duration; the number of layovers or transfers; price, baggage allowance; and the level of luxury, or lack thereof, they will receive. This know-before-you-buy model exists in nearly every market in the United States except one: healthcare.

The healthcare market exists as an outlier for several reasons. First, third parties (for example insurers or self-funded employers), not consumers, have historically paid most health

care bills. Because of this third-party involvement, consumers have traditionally not been interested in knowing the cost of healthcare, so long as they didn't have to pay for it out-of-pocket. (Unfortunately, there was little incentive for consumers to understand that over utilization or high medical prices directly affected the size of their insurance premiums).

That situation began to change as healthcare insurers and employers began requiring that consumer have "more skin in the game..." That is, over the past few decades, more healthcare costs have been shifted by insurers and employers onto employees and other individuals. Now, more consumers have insurance policies with higher co-pays, deductibles, co-insurance, and other direct out-of-pocket expenses. Now, even though there is growing awareness of the high cost of healthcare, consumers lack the necessary knowledge and tools to navigate the healthcare pricing system for non-emergent care.

States have taken varying routes to address the lack of transparency in healthcare pricing. While flexibility allows states to tailor their laws as needed, it can also lead to a patchwork of policies. Existing provisions often lack uniformity and there appears to be disagreement, both within states and nationally, as to what price information would be most helpful to consumers and how best to relay that information.

The problem has even spilled over into the federal government. Rules recently adopted by the Center for Medicaid and Medicare Services are aimed at making the prices insurers pay hospitals more transparent, and plans have been developed to relay the prices paid by consumers as well.[4] Regardless of whether it is a state or the federal government tackling price transparency, the most significant obstacle is how to drill down and expose the actual, and sometimes different, prices the insured and uninsured pay for healthcare.

This paper explores differing approaches to healthcare price transparency across the nation and creates a system to evaluate these systems. Through careful research and evaluation, each state was placed in either Tier 1, 1A, 2, 2A, or 3. Tier 1 has the most rigorous cost-estimate transparency laws requiring both providers and carriers to give price information that reflects, as much as possible, the amount a consumer would have to pay. Tier 1A is slightly less rigorous and only requires that either providers or carriers give price information, Tier 2 states only require price estimates when certain requirements are met, Tier 2A is for states that provide comprehensive estimates through a web tool, without a legal requirement, and Tier 3 states appear to have no laws regarding personalized cost estimates, though they may have laws goving other transparency efforts.

## Tier 1 States:
## Alaska, Massachusetts, and Minnesota

These states require that consumers have access to cost estimates from all providers, including hospitals, doctors, clinics, and all insurance carriers. While cost estimate information must be available in all cases, consumers in these states have to request the information from providers or initiate a search through an insurer's cost-estimator tool to obtain these estimates.

### Alaska

In Alaska, providers and insurance carriers are given up to 10 days to provide a price estimate.[5] State law states that patients can request estimates orally, in writing, or electronically from their healthcare providers, facility, or insurer.[6] However, it does not mandate that carriers establish procedures for patients to obtain an estimate. There is no mention of requiring a toll-free number or a website for patient access.

### Massachusetts

Under Massachusetts law, both carriers and providers of all types are required to make cost estimates available upon request within two business days if phone or email is used.[7]

In addition, and most importantly, carriers are required to provide a real-time website for consumers and toll-free numbers to obtain estimates that allow comparison among care options. These "cost estimator tools" that carriers provide must show not only a consumer's out-of-pocket cost, but also the consumer's remaining deductible, if any, and the amount the insurer pays each provider.

Providers are also required to make estimates available to patients upon request. If an estimate cannot be made due to inability to predict what the specific treatment will be, a maximum allowed amount, the amount paid by the insurer, will be quoted to the consumer prior to admission.

There is also "CompareCare", a state-run online cost-estimator tool created by the state's Center for Health Information and Analysis (CHIA) that is based on data collected from the APCD, which allows patients to compare estimated costs from different hospitals based on their insurance provider.[8] The tool allows consumers to compare hospitals within a certain number of miles from the specified zip code. However, this tool is not applicable to those who are uninsured. (In Massachusetts, 97 percent of the population is insured by either public or private payers.)

The tool provides information on the average cost of services from specific healthcare providers and facilities. The state tool is in serious need of updating, as the current data is from 2015.[9] The Commonwealth's tool was not intended to replace or compete with insurers' cost estimator tools. In fact, the Commonwealth's CompareCare website clearly directs consumers to their insurers' cost estimator tools for more detailed and recent cost estimates.

### Minnesota

Minnesota law allows providers and carriers up to 10 business days to produce estimates.[10]

Carriers and health plan companies[11] must provide the insured with a good faith estimate of the allowable amount they will pay a specific in-network provider for the specified healthcare service, as well as the portion of the allowable amount that would be an out-of-pocket cost to the insured.

Healthcare providers[12] must present a good faith estimate for the services that will be provided, specifying what portion will be covered by the patient's healthcare carrier. This estimate includes the amounts that would be required for any facility fees.

For those who are uninsured, a healthcare provider will provide an estimate of the amount the consumer will be required to pay for the specified service, and for those who are insured, the provider is to give a good faith estimate of the "average allowable reimbursement the provider accepts as payment from private third-party payers."

Minnesota does not mandate that carriers establish procedures for patients to obtain an estimate from their carrier. There is no mention of requiring a toll-free number or a website for patient access.

## Tier 1A States:
## Florida, Nebraska and Tennessee

These states differ from Tier 1 states only because their state laws mandate that either providers or carriers are required to give estimates. This does not mean that consumers have the right to pick which entity they want to receive the estimate from, but only that they have the right to an estimate from either providers or carriers, whichever entity the law specifies. This limits the information to which consumers have access. As in Tier 1, these estimates are only required in nonemergency cases.

### Florida

Under Florida law, a patient, upon request to a hospital, is entitled to both a non-personalized estimate of costs for anticipated services, and a personalized estimate as well, within seven business days of such request.[13] The hospital must also advise patient requestors in writing that they should contact their health insurer or HMO for anticipated cost-sharing responsibilities.[14] Hospitals have to make available a website regarding the availability of cost estimates.

In 2019, Florida passed the Patient Savings Act, which is an optional shared savings incentive program for insurance carriers.[15] When used by carriers, this program offers a cash incentive for an insured consumer who chooses certain lower-cost shoppable health care services in non-emergent cases.

Florida also has a state-run website called the Florida Health Price Finder[16], which allows consumers to view the range and average costs for different procedures and to see how costs compare to national averages. Florida patients are also entitled to other transparency protections outlined in the "Florida Patient's Bill of Rights and Responsibilities."[17]

It does not appear that Florida has transparency laws requiring physicians or providers other than hospitals to give cost estimates to patients and there does not appear to be a requirement that insurers make out-of-pocket costs available to their members, although the law governing hospitals does send patients to their insurers for such information.

### Nebraska

The Nebraska price disclosure law is optional for insurance carriers, and if they opt into the state law, they are given two working days to provide cost estimates.[18] Estimates of out-of-pocket costs can be obtained from carriers who opt in through a website tool or a toll-free phone number. Similar to Massachusetts, carriers are required to have a website and toll-free number that a patient can use to obtain an estimate.

Healthcare provider facilities within a patient or prospective patient's network are required to provide the allowed amount for the specified nonemergency service or procedure, including facility fees, within three working days.

In addition, the program offers shared savings for patients "who elect to receive shoppable health care services[19], covered by their plan, from providers who charge less than the average price paid by their insurance carrier for that shoppable health care service." [20] The shared savings is paid in cash to the patient and is at least 50 percent of the saved cost when savings are over $50[21].

### Tennessee

In Tennessee, a recently passed law went into effect on January 1, 2020.[22] With this law, any carrier offering health insurance within the state must create an online tool and provide a toll-free phone number that gives enrollees access to a good faith estimate of the out-of-pocket cost the enrollee should expect to pay with consideration to their own health plan.

The law also requires each carrier to offer incentive programs to enrollees "who elect to receive a comparable healthcare service from a network provider that is covered by the health plan and that is paid less than the average allowed amount paid by that carrier to network providers for that comparable healthcare service before and after an enrollee's out-of-pocket limit has been met." These incentives can be a cash payment, a credit toward the enrollees' deductible, or a reduction of a premium, copayment, or cost sharing[23].

## Summary of Tier 2 States:
## California, Maine, Montana, New Jersey, Rhode Island, South Dakota, Texas, Vermont, and Virginia.

Tier 2 states require that consumers have access to cost estimates only in certain cases (in- network vs. out-of-network), from

certain entities (e.g. carriers or hospitals or physicians), or only if you are uninsured. The difference is that the legal guarantee that patients can request a cost estimate for healthcare services does not apply to every provider or every patient. In all cases, consumers must request the information. Only 18 percent, or nine states, belong in the Tier 2 category. These states have laws with language that indicates that some patients, in some circumstances, can request personalized estimates. The specific conditions vary by state.

### California

In California, a law requiring written estimates upon request only applies to those who are uninsured.[24] Uninsured individuals can receive estimates during normal business hours, though there is no guaranteed time period within which a patient will receive an estimate. As with all other states, this policy does not apply to emergency services.

Hospitals, except those designated as "small and rural," are required to make their chargemasters public and have a copy available in their respective emergency, admissions, and billing offices.[25] They must also submit average charges for a list of 25 common outpatient procedures.[26]

Health plans are restricted from including any sort of provision in their policies that restricts their ability to provide a member with the "cost range" for any type of procedure or service related to treatment.[27] It is important to note that this law is not equivalent to a law that guarantees estimates.

California law also requires that a Health Care Cost Transparency Database be "substantially completed" by July 1, 2023.[28] The goal of this database is to "provide greater transparency regarding healthcare costs, and the information may be used to inform policy decisions regarding the provision of quality healthcare, reduce disparities, and reduce healthcare costs."[29]

### Maine

In Maine, small group carriers[30] are required to provide price estimates for "comparable health care services".[31,32] Carriers are required to provide an estimate[33] "based on a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association provided to the enrollee by the provider."[34] If specific code information regarding the service in question is obtained by the carrier per request of the enrollee, the carrier will provide the estimated out-of-pocket costs based on the specific information supplied by the provider.

Carriers must have a website and a toll-free phone number for patients to obtain cost estimates and estimated out-of-pocket calculations. Providers are required to give all patients written notification of the availability of carrier transparency tools and the option that patients can pick from different providers. Uninsured patients can request "an estimate of the total price of medical services to be rendered directly by that health care entity during a single medical encounter."[35]

Additionally, a shared savings incentives program was created in January 2019, in which enrollees of small group health plans receive incentives such as gift cards or premium reductions to shop for lower-cost, high-quality care. This program will sunset unless it is renewed.[36]

Finally, the Maine law includes a unique provision that enables a patient to obtain a covered service out-of-network, as long as its price is below the in-network average (which can be calculated using the Maine Health Data Organization website mentioned below), and the patient still receives credit toward in-network out-of-pocket responsibility.[37]

A previously passed law requires hospitals and ambulatory surgical centers to provide the average charge for any inpatient or outpatient service, upon request.[38]

The Maine Health Data Organization operates a website called CompareMaine[39] that allows users to compare the average cost of specific services at various hospitals.

### Montana

Patients are only entitled to price information if the treatment costs more than $500.[40] All healthcare providers, hospitals, clinics, and surgical centers must give a good faith estimate for the treatment or service in question. Estimates must be provided within 10 business days.[41]

When the cost of the service or procedure is above the $500 threshold, carriers are required to provide an explanation of the coverage for the service or treatment in conjunction with the estimate provided by the healthcare provider.[42] There is not a specified number of days by which this explanation of coverage has to be provided.

Additionally, the Montana Hospital Association has a web tool that enables users to search by county or city for a limited number of procedures. The search has information on the average price of a procedure for the hospitals in that region or for the selected hospital, along with several other pieces of information, such as average length of stay.[43]

### New Jersey

Estimates are only available in one very specific circumstance: if a patient is insured and scheduling a non-emergent service or procedure that is out-of-network, she is entitled to request a written cost-estimate.[44] An exception is that if the procedure or service is not scheduled, the estimate can be made verbally. Healthcare professionals must disclose to the patient before scheduling a procedure if they are in- or out-of-network.

Additionally, the New Jersey Hospital Association operates a website called New Jersey Hospital Price Compare which allows users to see the average and median charges for different procedures in different hospitals.[45] It also allows users to compare charges for a procedure compared to county-wide and state-wide averages and medians.

### Rhode Island

Estimates are only required by hospitals if requested by an individual without health insurance or with a deductible of $5,000 or more.[46] The estimates are for the amount that will be paid for certain services. This only applies to non-emergent services at hospitals. Written estimates must be provided within two business days.[47]

### South Dakota

Healthcare providers, including licensed healthcare facilities, physicians, dentists, and psychologists, must disclose all fees and charges for services or procedures when requested.[48] Failure to comply is grounds for disciplinary action by the licensing agency. Cost disclosure does not appear to apply to carriers.

Additionally, hospitals must report charge information for all procedures with 10 or more cases in the previous 12 months to the South Dakota Association of Healthcare Organizations. This information is used to create and annually update a website called the South Dakota Hospital Pricepoint System[49], which discloses only information about hospital charges. The website allows users to compare hospitals or view a report of one hospital's prices in detail. The law allows patient access to average and median price information.[50]

### Texas

Health facilities must have policies in place for patients to request "an estimate of the facility's charges" for all elective inpatient admissions and all nonemergency outpatient surgical procedures prior to the scheduling of said procedure.[51] After the initial request, an estimate must be provided within 10 business days.[52]

The facilities must also have policies in place to allow uninsured residents to request "any discounting of facility charges." In the law, the consumer is instructed to "…contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance...".[53]

A website run by the Texas Department of Insurance called the Texas Health Compare provides tips on how to estimate costs and investigate provider quality.[54] Another Department of Insurance website called Texas Healthcare Costs Consumer Information Guide allows users to pick a region and procedure, and then see the in- versus out-of- network costs for the selected procedure, as well as the selected region's total billed and total allowed costs compared to the statewide total billed and total allowed.[55]

### Vermont

According to a recently passed law, patients now have the right "to receive an itemized, detailed, and understandable explanation of charges regardless of the source of payment and to be provided with information about financial assistance and billing and collections practices" when receiving care at a hospital.[56] The same explanation of charges must be provided if the patient receives treatment at an ambulatory surgical center.

The law is unclear whether this information is always available ahead of time or only after the healthcare services are obtained. No timeframe was given for when this information must be provided.

### Virginia

Every hospital must provide, upon request by a patient or patient's legal representative, "an estimate of the payment amount for which the participant will be responsible for such elective procedure, test, or service."[57] The request must be made at least three days in advance of the procedure.

Beginning this year, carriers must offer enrollees a website and toll-free numbers to compare out-of-pocket estimates among providers for "comparable health care services."[58,59] The carrier tools must allow for comparison among care options, provide estimated out-of-pocket amounts, and allow patients to see average allowed amounts. Like Maine, Virginia policymakers paired transparency with a shared savings incentive for patients on small group plans. Starting in 2021, patients will be able to shop for lower than the average allowed amount (i.e. what was paid by a carrier to a provider).[60] The incentive may be cash payments; gift cards; or credits or reductions of premiums, copayments, or deductibles.[61]

Additionally, healthcare providers and health maintenance organizations will submit data to the commissioner.[62] This information is made available through Virginia Health Information, a website which has a tool that allows users to see the statewide median and range of cost for approximately 35 procedures.[63] The tool also has an interactive graphic that breaks down the potential costs of each procedure by category, facility, physician, surgeon, radiologist, or other cost sources.[64]

## Summary of Tier 2A States: New Hampshire and Washington

Tier 2A states have no laws requiring an out-of-pocket personal estimate, but do offer an online tool that can provide an estimate that takes insurance into account and has been made available to consumers. These tools do not guarantee a patient's right to an estimate, as state law does not require providers or insurers to provide such information.

New Hampshire and Washington currently do not have laws requiring healthcare price estimates but have online tools that allow users to input their insurance information to generate a somewhat personalized estimate for a specific service or procedure. The resulting cost estimate may not be exact, but it is more personalized than a generic estimator. However, these

cost estimator tools are not required by law for carriers, users in these states have no legal right to a cost estimate. If there is a procedure not listed on the site, there appears to be no guarantee that a patient would be able to procure an estimate by other means.

For this reason, New Hampshire and Washington are not Tier 1 or 1A states. Tier 1 designation indicates that there is a law or laws that require an estimate in all cases, and Tier 1A indicates that either providers or carriers are required to give estimates. Neither is the case in New Hampshire or Washington.

### New Hampshire

NH Health Cost is New Hampshire's healthcare cost-estimator tool run by the New Hampshire Department of Insurance.[65] The tool has a disclaimer that states that the tool is not a personalized estimate, nor does it represent what a patient's actual bill will be.

Users are prompted to select their insurance carrier or select the no insurance option. Based on the selection, the estimate provided will reflect actual average prices previously paid by those with the same insurance carrier. Over 120 procedures and services are available for price estimates. The estimates reflect bundled costs and the search results display every hospital in New Hampshire for which data is available for that procedure or service. The estimated total cost; the precision of the cost-estimate—low, medium, or high—and the typical patient complexity in that procedure are also reported.

If, at the beginning of the search, a user selects "uninsured", it will show the discount each hospital provided for those without health insurance and how much one would pay before and after the discount. Users can also click on a specific provider after searching for a procedure and see the cost of all other services and procedures provided by that provider. There is also a separate, similar search tool available for dental services.[66]

Detailed data on quality of care is provided with four categories rating quality at different providers: patient-centered care, timely care, effective care, and safe care.[67]

If the user needs an estimate that is not available through NH Health Cost, there is less precise data available on a much wider range of procedures located through an icon in the top right corner of the NH Health Cost home page.[68]

### Washington

Washington HealthCareCompare is the healthcare cost-estimator tool established by the state's Office of Financial Management[69]. Once at the website, users are asked to input their zip codes and the procedures for which they would like an estimate. There are over 85 services and procedures from which to choose. The search displays the typical price of a procedure in Washington, the typical high and low range, and states what is included in the price shown. It also explains the procedure and the corresponding year to which the price information applies.

After the initial search, users have the option to input their insurance information to receive a more personal cost estimate. The user inputs the estimated cost of the procedure, his deductible, co-insurance, co-pay, and maximum.

Users can compare all the information listed above for providers within the range of the zip code that was provided. Users can also click on a specific provider to learn more about the quality information of that facility in three categories: good treatment results, keeping hospital patients safe, and hospital quality care.

## Summary of Tier 3 States:

Alabama, Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Utah, West Virginia, Wisconsin, and Wyoming.

Tier 3 states either have no requirements to give patients out-of-pocket price estimates or such loose requirements that they appear to not be very helpful to consumers looking to acquire cost information prior to obtaining healthcare services. That said, some of these states in Tier 3 engage in other transparency efforts, such as public web tools, but they still fall short of Tiers 1, 1A, 2 and 2A. Seventy-two percent, or 33 states, are in the Tier 3 designation. These states have no laws requiring price estimates, but they may have laws that require other transparency provisions.[70]

To help understand Tier 3 states better, they are organized below into subcategories 1 and 2.

***Subcategory 1:*** *States that have a privately or government-run online cost estimator tool (that does not allow for personal insurance information)*

***Subcategory 2:*** *States that do not have a privately or government-run online cost estimator tool*

For a state to qualify for subcategory 1, the cost-estimator tool must be easy to use and provide adequate information. Web tools provided by individual carriers or specific hospital chains or organizations were not considered. Services that are not free to users were also not considered.

Links to the web tools are provided in Table 1.

# Table 1. Tiering of States for Price Transparency

## Tier 1

| Law requiring price estimates from both carriers and providers | |
|---|---|
| Alaska | Minnesota |
| Massachusetts | |

| Tier 1A – Law requires estimate from either all carriers or all providers | |
|---|---|
| Tennessee | Nebraska |
| Florida | |

## Tier 2

| Law, but limited | |
|---|---|
| California | South Dakota |
| Maine | Texas |
| Montana | Vermont |
| New Jersey | Virginia |
| Rhode Island | |

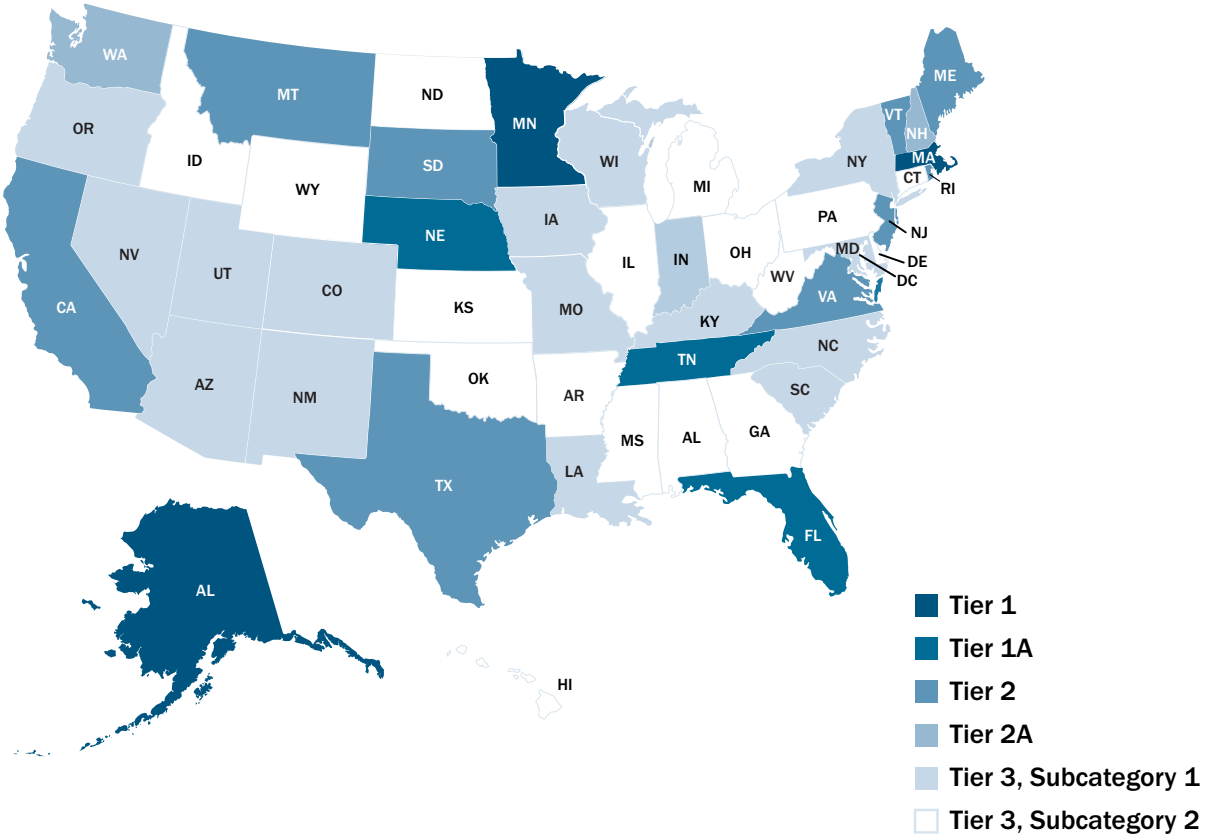
| Tier 2A – No law, but good webtool | |
|---|---|
| New Hampshire | Washington |

## Tier 3 – No law or loose transparency

| Subcategory 1 – Has a webtool | |
|---|---|
| | Website |
| Arizona | https://pub.azdhs.gov/hospital-discharge-stats/2011/index.html |
| Colorado | https://www.civhc.org/shop-for-care/ |
| Indiana | http://www.mycareinsight.org/ |
| Iowa | http://www.iowahospitalcharges.com/ |
| Kentucky | http://info.kyha.com/ |
| Louisiana | https://www.lahospitalinform.org/ |
| Maryland | https://www.wearthecost.org/ |
| Missouri | https://focusonhospitals.com/ |
| Nevada | http://www.nvpricepoint.net/Basic_INP.aspx |
| New Mexico | http://nmhealthcarecompare.com/ |
| New York | https://www.youcanplanforthis.org/ |
| North Carolina | https://info.ncdhhs.gov/dhsr/ahc/hb834/search.asp |
| Oregon | https://oregonhospitalguide.org/find-a-hospital/ |
| South Carolina | http://scpricepoint.org/ |
| Utah | https://le.utah.gov/xcode/Title26/Chapter33A/26-33a-S106.5.html?v=C26-33a- S106.5_2019051420190514 |
| Wisconsin | https://www.wipricepoint.org/Home.aspx |

| Subcategory 2 – No web tool | |
|---|---|
| Alabama | Michigan |
| Arkansas | Mississippi |
| Connecticut | North Dakota |
| Delaware | Ohio*[71] |
| Georgia | Oklahoma |
| Hawaii | Pennsylvania |
| Idaho | West Virginia |
| Illinois | Wyoming |
| Kansas | |

## Graphic Representation of Tier Designations




## Conclusions

In every state, including Tier 1 states, there are improvements that could be made to make healthcare pricing more transparent for patients. No cost estimator tool is perfect; there are many ways that states could improve their web tools, such as by making them more consumer friendly, more visible promotion of their availability, offering cash rewards or other incentives for members to choose high-value/lower-cost providers, or creating easy to use iPhone apps. In addition, state governments can assert much more leadership just by using their bully pulpits to pull together the healthcare, commercial, retail, educational, and consumer sectors to raise the profile of price transparency and to promote its adoption.

Due to the patchwork of state healthcare price transparency laws, recommendations will apply differently in each state. More uniform meaningful healthcare price transparency practices will only help patients as they interact with various care options from different providers over time.

1. ***Require or incent personalized cost estimates in all non-emergent cases.*** Every state should be able to fit into a Tier 1 designation and require that all facilities, providers, and carriers provide personalized cost estimates in all non-emergency cases, whether the patient is insured or uninsured. There should be a reasonable turnaround period allotted for patients to receive estimates. Carriers, providers, and facilities should work cooperatively to provide patients with the most accurate estimate possible with the available information. Carriers should set up a toll-free phone number and a web tool for insured consumers to obtain a personalized cost-estimate.
2. ***Create methods to educate individuals about the tools and resources available to them.*** According to a 2017 survey conducted by Public Agenda, 51 percent of people who have not tried to find out the price of medical services before getting care are not sure how to do so.[72] Additionally, 56 percent of Americans are not aware that doctors' prices vary. If people are not aware that tools exist to answer their questions and give them access to cost estimates, the tools will go unused and fail to serve their purpose. If Americans are not even aware that prices can vary, why would they shop around for better prices?

   Individuals need to be educated on the availability of these tools. To achieve that, two steps should be taken:
   - Carriers should ask insured consumers if they want to opt into text messages or email notifications that would alert them about the tools and cost saving measures

available for use and the steps for how to use them.
- Primary care providers (PCPs) have the most regular interactions with individuals in healthcare settings. PCP practices and administrators should be more proactive in educating patients about healthcare prices and their available options.

3. ***Leverage cost estimator web tools.*** Without a way to easily compare costs for procedures and services from different facilities and providers, access to a cost estimate will not do much good. Prices need to be transparent and comparable for patients to shop around and find the best quality for the lowest price, ultimately driving prices down.

   In some states, APCDs help in this effort. In others, private-sector tools are often more flexible and consumer friendly. States should seek to partner with the private sector to expand access to such tools or at minimum work to release any data the state is collecting to increase the number of patients with access to good quality pricing data.

   All web tools need to be able to:
   - Compare prices of procedures and services at different facilities and among providers.
   - Provide the estimated average cost and range of cost of bundled care for specific insurers and plans.
   - Provide a description of what is included in each bundled care price for each searchable procedure and service cost estimate.
   - Inform uninsured users of the amount of any discount at each facility or provider and the final price after the discount.
   - Inform users if they are viewing in- or out-of-network providers.
   - Make available facility and provider quality and safety information for every facility or provider, when applicable. This information should also be comparable.
   - Where appropriate, provide direct links to carriers' cost estimator tools.

## Appendix 1: Methodology

This information in this report was gathered as of July 2019. Any laws, regulations, provisions, or other transparency efforts put into effect or publicized after that date are not included, unless noted. This report may not capture every aspect of healthcare pricing transparency for every state due to the ever- changing landscape of state-by-state healthcare policy.

We used the two sites below as a starting place to gather information about current transparency efforts that exist.

The Source on HealthCare Price and Competition, an academic website that aims to "serve as a catalyst for change within the U.S. healthcare system."[73] The website is essentially a collection of healthcare laws in all 50 states from as early as 2015. Two of The Source's key issue areas are "Healthcare Costs" and "Price and Quality Transparency." These were the two sections researched for this paper. Only laws listed as "Enacted" were further investigated and included in this paper. Only laws that regarded cost-estimates or personal estimates were included and other topics such as pharmaceutical gag clauses and surprise billing laws, while very important, were not included in the scope of this paper.

Additionally, the National Conference of State Legislatures has a page on its website titled "Transparency and Disclosure of Health Costs and Provider Payments: State Actions" which lists the legislation passed in each state regarding healthcare price transparency up through March of 2017. Not all states are listed on this site because not all states have relevant legislation. This site was utilized as a cross reference to check if anything was missing from the Source on HealthCare site.[74]

After applicable, enacted laws were found on these two sites, they were further researched on their home state's legislature website.

We also spoke with think tank staff involved in price transparency efforts to learn more about certain state reforms.

Extensive online research was also conducted. Through web searches, transparency efforts carried out by non-governmental entities were found, such as cost-estimator tools established by state hospital associations.

## Endnotes

1 Pioneer Institute. "*Massachusetts Consumer Healthcare Price Transparency Survey.*" Slide 10. November 2019.

2 Ibid, slide 12.

3 Ibid, slide 19.

4 Health and Human Services Press Office. *"Trump Administration Announces Historic Price Transparency Requirements to Increase Competition and Lower Healthcare Costs for All Americans."* November 15, 2019. Retrieved from https://www.hhs.gov/about/news/2019/11/15/trump-administration-announces-historic-price-transparency-and-lower-healthcare-costs-for-all-americans.html

5 http://www.akleg.gov/PDF/30/Bills/SB0105Z.PDF

6 http://www.akleg.gov/PDF/30/Bills/SB0105Z.PDF

7 https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224

8 https://masscomparecare.gov/

9 Ibid. When comparing costs for preventive care and office visits, the tool allows you to look at "Physician Profiles" by clicking on the info button which provides information such as which insurers the doctor accepts, what their area of specialty is, along with a lot of other important information.

10 https://www.revisor.mn.gov/statutes/cite/62J.81

11 Any licensed insurance company in Minnesota excluding Medical Assistance (Minnesota's Medicaid program) or MinnesotaCare (insurance for low-income individuals). https://www.revisor.mn.gov/statutes/cite/62J.03#stat.62J.03.8

12 Ibid. Any person or organization that provides healthcare other than a nursing home.

13 https://www.flrules.org/gateway/ruleNo.asp?id=59A-3.256

14 Ibid

15 http://www.flsenate.gov/Session/Bill/2019/524/BillText/Filed/PDF

16 https://pricing.floridahealthfinder.gov/#!

17 http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-

18 https://nebraskalegislature.gov/FloorDocs/105/PDF/Slip/LB1119.pdf

19 Ibid. Shoppable health care service means a health care service for which an insurance carrier offers incentive payments under a shared savings incentive payment program established by the insurance carrier. Shoppable health care service includes, at a minimum, health care services in the following categories: (a) Physical and occupational therapy services; (b) Obstetrical and gynecological services; (c) Radiology and imaging services; (d) Laboratory services; (e) Infusion therapy; (f) Inpatient or outpatient surgical procedures; and (g) Outpatient nonsurgical diagnostic tests or procedures.

20 https://nebraskalegislature.gov/laws/statutes.php?statute=44-1407&print=true

21 Ibid.

22 http://wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=SB0510&GA=111

23 Ibid.

24 https://law.justia.com/codes/california/2005/hsc/1339.50-1339.59.html

25 http://www.leginfo.ca.gov/pub/05-06/bill/asm/ab_1001-1050/ab_1045_bill_20051005_chaptered.html

26 https://oshpd.ca.gov/data-and-reports/cost-transparency/hospital-chargemasters/

27 https://law.onecle.com/california/health/1367.49.html

28 http://sourceonhealthcare.org/legislation/ab-1810/

29 Ibid.

30 "Small group health plan" means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract covering an eligible group. "Small group health plan" does not include the following types of insurance: (1) Accident; (2) Credit; (3) Disability; (4) Long-term care or nursing home care; (5) Medicare supplement; (6) Specified disease; (7) Dental or vision; (8) Coverage issued as a supplement to liability insurance; (9) Workers' compensation; (10) Automobile medical payment; or (11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance. https://legislature.maine.gov/statutes/24-A/title24-Asec2808-B.html

31 "Comparable health care service" means nonemergency, outpatient health care services in the following categories: (1) Physical and occupational therapy services; (2) Radiology and imaging services; (3) Laboratory services; and (4) Infusion therapy services. http://legislature.maine.gov/statutes/24-A/title24-Asec4318-A.html

32 https://legislature.maine.gov/legis/bills/bills_128th/chapters/PUBLIC232.asp

33 Though it may appear that Maine belongs in Tier 1A because so many kinds of health plans are not required to provide estimates, it had to stay in Tier 2

34 Ibid

35 https://www.mainelegislature.org/legis/statutes/22/title22sec1718-C.html

36 https://legislature.maine.gov/legis/bills/bills_128th/billtexts/SP014701.asp

37 https://www.mainelegislature.org/legis/bills/bills_128th/chapters/PUBLIC232.asp

38 http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0698&item=3&snum=126

39 https://www.comparemaine.org/?page=choose#

40 https://leg.mt.gov/bills/mca/title_0500/chapter_0040/part_0050/section_0120/0500-0040-0050-0120.html

41 Ibid.

42 https://leg.mt.gov/bills/mca/title_0500/chapter_0040/part_0050/section_0180/0500-0040-0050-0180.html

43 http://www.montanapricepoint.org/Basic_INP.aspx

44 https://www.njleg.state.nj.us/2018/Bills/A2500/2039_I1.HTM

45 http://www.njhospitalpricecompare.com/Information/Search

46 http://webserver.rilin.state.ri.us/billtext17/senatetext17/s0146.htm

47 Ibid

48 http://sdlegislature.gov/Statutes/Codified_Laws/DisplayStatute.aspx?Statute=34-12E&Type=Statute

49 http://www.sdpricepoint.org/

50 South Dakota Legislature, 34-12E-13

51 https://statutes.capitol.texas.gov/Docs/HS/htm/HS.324.htm

52 Ibid

53 Ibid.

54 http://www.texashealthoptions.com/compare/index.html

55 https://texashealthcarecosts.org/

56 https://statenet.lexisnexis.com/symtree/xmlbill/VT/2019000/S/31/BILLTEXT_20190610_0_EF.pdf

57 https://lis.virginia.gov/cgi-bin/legp604.exe?161+ful+HB905ER

58 "Comparable health care service" means any (i) physical and occupational therapy service, (ii) radiology and imaging service, (iii) laboratory service, (iv) infusion therapy service, and (v) at the discretion of the health carrier, other health care service, provided that with respect to any service described in clauses (i) through (v) the service (a) is a covered non-emergency health care service or bundle of health care services provided by a network provider and (b) is a service for which the health carrier has not demonstrated that the allowed amount variation among participating providers is less than $50

59 https://statenet.lexisnexis.com/symtree/xmlbill/VA/2018000/H/2639/BILLTEXT_20190321_0_EF.pdf

60 https://law.lis.virginia.gov/vacode/38.2-3462/

61 Ibid.

62 https://law.lis.virginia.gov/vacode/32.1-276.5

63 http://www.vhi.org/healthcarepricing/default.asp

64 Ibid.

65 https://nhhealthcost.nh.gov/costs/medical/step-1/

66 https://nhhealthcost.nh.gov/costs/dental/step-1/

67 https://nhhealthcost.nh.gov/quality/select

68 https://nhhealthcost.nh.gov/costs/medical/step-1/

69 https://www.hca.wa.gov/about-hca/washington-state-all-payer-claims-database-wa-apcd

70 This report does not include state laws that required posting of average price lists for common procedures because that information is not actionable for insured patients and does little to contribute to system wide transparency.

71 *Ohio is in the middle of an ongoing court case which is blocking a comprehensive price transparency law from going into effect. If this law did go into effect, it would place Ohio is Tier 1A, but as of right now with no way to act on the law, Ohio is in Tier 3 Subcategory 2. Here is an article explaining the situation further — https://www.daytondailynews.com/news/ohio-health-care-transparency-law-blocked-judge-decision/iHZnaOGyxPdwaSkgTXbaEL/

72 https://www.publicagenda.org/files/PublicAgenda_StillSearching_2017.pdf p.49

73 http://sourceonhealthcare.org/

74 http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx

## About the Authors

**Caterina DiBiase**, the primary author of this report, is graduating this Spring with a Masters Degree in Public Policy from the University of Massachusetts in Amherst where she specialized in social justice and public health. She was a member of the accelerated masters degree cohort. From September 2019 to January 2020, Caterina served as a Pioneer Research Assistant in Healthcare Policy working with Seniors Fellows on various healthcare projects including healthcare price transparency and direct primary care in Massachusetts. Previously, she was a Research Assistant with the UMass Amherst School of Public Health and Health Sciences, and the UMass College of Social and Behavioral Sciences. Caterina graduated with a Bachelor of Science, Public Health and Political Science, *cum laude*, in 2019 from UMass Amherst.

**Lauren Corvese** is Pioneer's Research Assistant and Development Coordinator. She joined Pioneer in 2015 as a co-op student, writing on education, healthcare, and transportation policy in Massachusetts. Lauren recently earned a Bachelor of Arts in Political Science from Northeastern University, where she graduated summa cum laude.

**Scott Haller** graduated from Northeastern University with a Bachelor's Degree in Political Science. He started working at Pioneer Institute through the Northeastern's Co-op Program and was the Lovett C. Peters Fellow in Healthcare. While Scott's original focus was on the MBTA, he has shifted his focus towards healthcare price transparency. He previously worked at the Massachusetts Office of the Inspector General.

**Barbara Anthony**, lawyer, economist, and public policy expert, is a Senior Fellow in Healthcare Policy at the Pioneer Institute. She was also a former Senior Fellow and Associate at the Harvard Kennedy School's Center for Business and Government where she researched and wrote about Massachusetts market reform and healthcare cost containment efforts. She served as Massachusetts Undersecretary of the Office of Consumer Affairs and Business Regulation from 2009 to 2015 and has worked at the intersection of federal and state commercial regulation and the business community for many years. Among other positions, Anthony served as the Director of the Northeast Regional Office of the Federal Trade Commission in Manhattan, and was a top deputy to the Massachusetts Attorney General. She began her career as an Antitrust Trial Attorney at the U.S. Justice Department in Washington, D.C. Anthony is a well-known consumer advocate and regularly appears as a media commentator on consumer protection and business regulation issues.

**Josh Archambault** is a Senior Fellow at Pioneer Institute. Prior to joining Pioneer, Josh was selected as a Health Policy Fellow at the Heritage Foundation in Washington, D.C. In the past, Josh served as a Legislative Director in the Massachusetts State Senate and as Senior Legislative Aide in the Governor's Office of Legislative Affairs. His work has appeared or been cited in outlets such as *USA Today*, *Wall Street Journal*, *The New York Times*, *Fox News*, *NPR*, *Boston Herald* and *The Boston Globe*. He is the editor and coauthor of *The Great Experiment: The States, The Feds, and Your Healthcare*. Josh holds a Master's in Public Policy from Harvard University's Kennedy School and a BA in Political Studies and Economics from Gordon College.

**Seher Chowdhury** is graduating this Spring from the Boston University School of Public Health (BUSPH) with a Masters Degree in Public Health; her areas of specialization include Health Policy & law and Epidemiology and Biostatistics. She has been a Pioneer Research Assistant in Healthcare Policy since June 2019. She has worked extensively in the area of healthcare price transparency along with Pioneer's Senior Fellows. She participated extensively in Pioneer's first state poll and analysis of consumers' attitudes toward healthcare price transparency. Outside of price transparency, her areas of interest include Medicaid reform and expansion; reproductive and minority health access and equity; and the intersection of health, human rights, and bioethics. Seher graduated from the University of California at Los Angeles (UCLA) in 2018 with a Bachelor of Science degree, where she completed a major in Biology and minor in Asian Languages (Korean concentration).

## About Pioneer

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to improve the quality of life in Massachusetts through civic discourse and intellectually rigorous, data-driven public policy solutions based on free market principles, individual liberty and responsibility, and the ideal of effective, limited and accountable government.

PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

185 Devonshire Street, Suite 1101 Boston MA 02110 617.723.2277
www.pioneerinstitute.org Facebook.com/PioneerInstitute Twitter.com/PioneerBoston