



Health Insurance Bulletin 2013-1

Health Care Price Transparency

(a) **Purpose.** This Bulletin is issued by the Office of the Health Insurance Commissioner for the purpose of communicating to health insurance issuers the Commissioner's interpretation of their obligations under state laws and regulations to disclose to certain health care providers the price of health care services. The Commissioner finds that there are significant variations in the price of health care services that are not attributable to the quality of the service, and that the disclosure of those price variations is necessary to enable providers to make cost-effective clinical referrals, care coordination, and other treatment decisions. The Commissioner finds that encouraging more cost-effective referrals and care coordination will protect the interests of health care consumers, and promote affordable health insurance. The Commissioner further finds that the fair treatment of providers requires disclosure of price information to providers with economic performance incentives connected to the cost-effectiveness of their referral, care coordination and other treatment decisions.

(b) **Authority.** This Bulletin is issued in accordance with, and pursuant to the Commissioner's authority under Rhode Island General Laws §§ 42-14.5-2, 42-14.5(e), and 42-14-4(c) and (d); OHIC Regulation 2, Sections 6(c), 7(c), 8(c), and 9(c), and 9(d)(iii)(A) and (D)(6); and Rate Approval Condition No. 6 (2012 Small and Large Group Rate factor Review: OHIC-2012-2). The Commissioner intends to take into consideration a health insurance issuer's compliance with the requirements of this Bulletin in discharging any of the duties of the Office, including but not limited to approving, disapproving, or modifying health insurance rates and forms.

The Commissioner acknowledges the comments of some stakeholders that as a matter of law the Commissioner should not take any action with respect to the price confidentiality provisions of existing provider reimbursement contracts. The existence of a contract provision which may be affected by

government regulation is not in itself a bar to the regulation so long as the regulation is reasonable and necessary to carry out a legitimate public purpose. Brennan v. Kirby, 529 A.2d 633, 638(R.I. 1987). The Commissioner finds that the central undertaking and inducement associated with the contract is payment for health care services rendered, a purpose which is left undisturbed by this regulation; conversely, the confidentiality provisions do not appear to have any real or ascertainable value. See Retired Adjunct Professors of R.I. v. Almond, 690 A. 2d 1342, 1347 (R.I. 1997); see also, City of El Paso v. Simmons, 379 U.S. 497, 85 S.Ct. 577, 586-587 (1965). The Commissioner further finds that the regulation of health insurance is pervasive, long-standing, and with respect to this Bulletin advances important public interests in affordable access to health care. R.I. Gen. Laws § 42-14.5-2. See Blue Cross Blue Shield of R.I. v McConaghy, (R.I. Superior Court, No. PC 04-6806, 2005). See also In re GTE Reinsurance Company Ltd., (R.I. Superior Court, No. PB 10-3777, 2011). The provisions of this Bulletin, moreover, are narrowly and reasonably tailored to the specific needs of health care providers to make cost-effective referrals, care coordination and other treatment decisions. See United States Trust co. v. New Jersey, 431 U.S. 1, 97 S.Ct. 1505, 1519 (1977).

(c) **Definitions.** As used in this Bulletin:

(1) "Chronic Care Sustainability Initiative" means the collaborative of health care providers and health insurance issuers convened by the Health Insurance Commissioner and by the Secretary of the Executive Office of Health and Human Services pursuant to R.I Gen. Laws chapter 42-14.6.

(2) "Commissioner" means the Commissioner of the Office of the Health Insurance Commissioner.

(3) "Designated health care provider" means (i) a health care provider participating in the Chronic Care Sustainability Initiative, (ii) a primary care provider, and (iii) any other health care provider designated by the Commissioner as having an economic incentive to make cost-effective referrals, care coordination and treatment decisions.

(4) "Enrollee" means an individual or dependent covered by the health benefit plan of a health insurance issuer.

(5) "Health insurance issuer" means any company of any kind doing health insurance business in this state, both domestic and foreign, including any person who offers, issues, or renews a health insurance policy, contract, or other health benefit plan in connection with covered members or

policyholders residing or located in Rhode Island, including but not limited to: a health insurance company subject to Rhode Island General Laws Chapter 27-18, a hospital, medical, or dental service corporation subject to Rhode Island General Laws Chapters 19, 19.2, 20, and 20.1, and health maintenance organizations subject to Rhode Island General Laws Chapter 27-41.

(6) "Health care provider" means any person licensed by the Department of Health to provide health care services in this state practicing under a participating provider agreement with a health insurance issuer, and includes the employees and agents of health care providers.

(7) "Health care facility" has the meaning defined in R.I. Gen. Laws § 23-17-2(6).

(8) "Price" means the allowable amount due to a health care facility, health care provider, or a seller of durable medical equipment, or medical supplies for a health care service or product after the application of any discount, write-off, contract or plan adjustment or allowance, or other reduction to the charge amount, and before the application of any individual member cost-sharing, including deductibles, co-payments, co-insurance, and out-of-pocket maximums.

(9) "Primary care provider" means the physician, practice or other medical provider considered by the enrollee to be his or her usual source or care.

(d) Disclosure of price information.

(1) On and after the effective date of this Bulletin, a health insurance issuer shall not enforce a provision in any participating provider agreement which purports to obligate the health insurance issuer or health care provider to keep confidential price information requested by a designated health care provider for the purpose of making cost-effective clinical referrals, care coordination, or treatment decisions.

(2) At the request of a designated health care provider, a health insurance issuer shall disclose in a timely manner to the health care provider such price information as is reasonably necessary for the designated provider:

- (A) to make cost-effective clinical referrals;
- (B) to engage in care coordination activities; or
- (C) to make other treatment decisions.

(3) A health insurance issuer may adopt reasonable policies and procedures designed to limit the disclosure of price information for purposes other than those identified in subsection (d)(2) of this Bulletin.

(4) The Commissioner may enforce the requirements of this Bulletin in accordance with OHIC Regulation 2, Sections 6, 7, 8, and 9.

(e) **Disclosure of price information to consumers and other providers.** On or before April 1, 2014, each health insurance issuer shall file for the Commissioner's approval its Comprehensive Price Transparency Plan. A Comprehensive Price Transparency Plan shall empower consumers and all health care providers to make informed and cost-effective health care decisions. In developing its Plan, the issuer shall:

(1) establish a time-line for implementation of the Plan;

(2) identify the health care services, products and supplies subject to price disclosure under the Plan, including but not limited to hospital in-patient and out-patient services, physician services, other health care provider services, medical imaging services, laboratory services, prescription drug prices, durable medical equipment, and medical supplies;

(3) identify the health services, products and supplies, if any, that are not subject to price disclosure under the Plan.

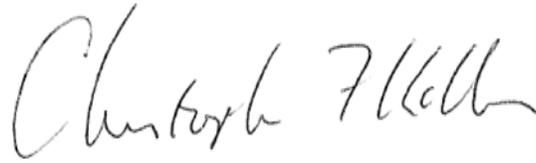
(4) establish the issuer's policies and procedures designed to limit disclosure of price information for purposes that would negatively impact the public interest in transparency, competition, and affordability.

(5) disclose price information with respect to services reimbursed on a fee-for service basis, as well as services reimbursed by alternative reimbursement mechanisms.

(6) demonstrate to the Commissioner that the issuer has solicited and considered the comments and recommendations of consumers, employers, health care providers, health care facilities, and other stakeholders in developing its Plan.

(7) submit to the Commissioner progress reports on the development of its Plan during August, 2013 and during January, 2014.

Dated at Cranston, Rhode Island this 20th day of May, 2013.

A handwritten signature in black ink that reads "Christopher F. Koller". The signature is written in a cursive style with a large initial 'C'.

Christopher F. Koller, Commissioner

Effective date: June 1, 2013