HOUSE BILL NO. HB0292

Wyoming Health Care Pricing Transparency Act.

Sponsored by: Representative(s) Burlingame and Senator(s) Rothfuss

A BILL

for

AN ACT relating to health care; creating the Wyoming Health Care Pricing Transparency Act; requiring insurers to provide specified health claims data to group purchasers of private health benefit plans as specified; providing penalties and civil liability for misuse of certain health claims data; specifying certain disclosures relating to health care facility charges; requiring a report; requiring the adoption of rules; specifying applicability; and providing for effective dates.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 26-43-301 through 26-43-307 and 35-2-618 are created to read:

ARTICLE 3

WYOMING HEALTH CARE PRICING TRANSPARENCY ACT

26-43-301. Short title.

This article may be cited as the "Wyoming Health Care Pricing Transparency Act."

26-43-302. Definitions.

(a) As used in this article:

(i) "Department" means the department of health;

(ii) "Health care provider" means a person or facility that is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession;

(iii) "Insurer" means any entity defined in W.S. 26-1-102(a)(xvi) that provides a private health benefit plan in this state and shall include a health maintenance

organization and the state employees' and officials' group health insurance plan and any provider of a plan made available under W.S. 9-3-201;

(iv) "Medical assistance" means as defined in W.S. 42-4-102(a)(ii);

(v) "Private health benefit plan" means as defined in W.S. 26-1-102(a)(xxxiii), and shall include a multiple employer welfare arrangement subject to state regulation, the state employees' and officials' group health insurance plan and any plan made available under W.S. 9-3-201, but excludes any employee welfare benefit plan, as defined in 29 U.S.C. § 1002, that is not subject to state regulation.

26-43-303. Health claims data access for group purchasers of private health benefit plans; standards; civil penalty for failure to provide data.

(a) Notwithstanding any contract or provision of state law that provides for the confidentiality of the information described in this section, an insurer which provides health insurance benefits to a group purchaser of a private health

benefit plan shall, upon written request and not more than two (2) times per year, provide the following data relating to the plan purchased by the group purchaser, at no charge:

(i) All raw claims data relating to benefits paid by the insurer on behalf of persons covered by the private health benefit plan over the preceding six (6) months in aggregated form;

(ii) Data relating to the claims of persons covered by the private health benefit plan which is necessary to allow the group purchaser to calculate the cost effectiveness of benefits provided by the insurer over the preceding six (6) months. This data shall include:

(A) Data required to calculate the insurer's actual rates or allowed costs relating to health care drugs, devices and services, organized by drug, device and service category or category of disease;

(B) Data relating to demographics, prescriptions, patient visits with a health care provider, inpatient services, outpatient services, diagnostic

procedures and laboratory tests of persons covered by the private health benefit plan;

(C) Data required to make calculations that are necessary to comply with the risk adjustment, reinsurance and risk corridor requirements of 42 U.S.C. §§ 18061 through 18063, as applicable;

(D) Data which may be used to establish an experience rating for persons covered by the private health benefit plan, including coding relating to diagnostics and procedures, the total amount charged to any person, including a health care provider and the person covered by the private health benefit plan, for each drug, device and service made available to the person and all payments or reimbursements made to any health care provider, administrator, pharmaceutical company, pharmacy benefit manager or medical device manufacturer relating to a drug, device or service made available to the person covered by the private health benefit plan.

(b) In addition to the data required to be provided under subsection (a) of this section, an insurer shall also

provide a summary report of the data required under paragraph (a)(ii) of this section, and include sufficient detail to demonstrate the percentage of increase or decrease in cost over the preceding five (5) years or the date on which the insurer first made a private health benefit plan available to the group purchaser, whichever is later.

(c) An insurer shall provide the data required by subsection (a) of this section in:

(i) A searchable electronic format; and

(ii) In the most detailed form that complies with federal law, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, and the Health Information Technology for Economic and Clinical Health Act, P.L. 111-5, as amended.

(d) A group purchaser shall not disclose the data provided by an insurer under this section to any other person, except a person under contract with the group purchaser to assist the purchaser with analysis of the data. A person under contract to analyze data with a group purchaser shall not

disclose the data made available under this section to any other person, except that the person under contract may provide a deidentified high level summary of the data to a group purchaser which contains a comparison of health care costs with other group purchasers. A violation of this subsection is punishable as specified in W.S. 26-43-304.

(e) An insurer shall not require a group purchaser to contract with the insurer to analyze the data made available under this section and, without limitation, shall not impose conditions on analysis of the data that are not imposed by this section.

(f) A group purchaser, and any person under contract with the group purchaser, shall have policies and procedures in place that are compliant with federal law, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, and the Health Information Technology for Economic and Clinical Health Act, P.L. 111-5, as amended, to ensure the privacy and security of the data made available under this section.

(g) An insurer that fails to provide the data required under subsection (a) of this section is subject to a civil penalty imposed by the department in the amount of ten thousand dollars ($10,000.00) per calendar quarter.

(h) As used in this section, "group purchaser" means:

(i) An employer with not less than fifty (50) employees enrolled in a private health benefit plan issued by an insurer who is required to disclose data under this section; or

(ii) A group of employers that cumulatively employ not less than fifty (50) employees as part of a multiple employer welfare arrangement subject to state regulation.

(j) An employee welfare benefit plan, as defined in 29 U.S.C. § 1002, which is not subject to state regulation, may provide the data required under subsection (a) of this section to group purchasers after entering into a written agreement with the department.

26-43-304. Penalties for misuse of health claims data; applicability.

(a) A violation of W.S. 26-43-303(d) shall be subject to the following:

(i) For a violation committed by a person who did not have knowledge of the violation or who failed to exercise reasonable care under the circumstances to prevent a violation, the person is subject to a civil penalty imposed by the department of not less than one thousand dollars ($1,000.00) and not more than ten thousand dollars ($10,000.00);

(ii) Except as otherwise provided by paragraph (iii) of this subsection, for a knowing violation or a violation based on willful neglect, the violation is a high misdemeanor and shall be punished by imprisonment for not more than one (1) year, a fine of not more than ten thousand dollars ($10,000.00), or both;

(iii) A knowing violation, or a violation based on willful neglect, with the intent to use, or allow another

person to use, the health claims data made available under this article for commercial advantage constitutes a felony and shall be punished by imprisonment for not more than five (5) years, a fine of not more than fifty thousand dollars ($50,000.00), or both.

(b) This section shall not apply to any alleged violation based on health claims data that is otherwise publicly available at the time of the alleged violation.

26-43-305. Civil liability for misuse of health claims data; applicability.

(a) A person damaged by a knowing violation of W.S. 26-43-303(d), or a violation of either section based on willful neglect, with the intent to use, or allow another person to use, the health claims data made available under this article for commercial advantage, may maintain a civil action against the person who committed the violation, whether or not the person was convicted of any offense under W.S. 26-43-304, and recover actual and consequential damages, reasonable attorney's fees and court costs relating to the damage.

(b) This section shall not apply to any alleged violation based on health claims data that is otherwise publicly available at the time of the alleged violation.

26-43-306. Applicability of Wyoming Governmental Claims Act.

Except as otherwise provided by the Wyoming Governmental Claims Act, this section shall not apply to any action or inaction of an employee or officer of a governmental entity, as defined in W.S. 1-39-103(a)(i).

26-43-307. Adoption of rules.

The department, in consultation with the department of insurance, shall adopt rules to implement this article.

35-2-618. Health care facility billing.

(a) Upon request, and not later than ten (10) business days after a patient's discharge from a health care facility, the facility shall provide to the patient, or the patient's

representative as authorized by federal law, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, an itemized statement of charges, a description of the health care drugs, devices or services provided to the patient and the procedural or diagnostic codes which relate to the provided drugs, devices or services. The bill shall also contain a due date for the itemized charges, unit price data relating to the charges and projected payments or reimbursements that may be made by an insurer. The statement shall also identify any facility charge or miscellaneous charges and explain their purpose and method of calculation.

(b) A health care facility shall ensure that all charges for drugs, devices and services made available by any health care provider during an episode of care at the facility are contained in a single bill which is provided to the patient, consistent with subsection (a) of this section.

(c) During an episode of care, a health care facility shall notify a patient before any drugs, devices or services are made available to the patient from a health care provider which does not maintain participating provider status with

the patient's insurer. As used in this subsection, "services" shall include a patient visit with a health care provider or a consultation between health care providers relating to a patient.

(d) A health care facility shall make available to a patient a standard list of charges for drugs, devices and services at the facility and any facility charge or miscellaneous charges that may be imposed. The facility shall annually update this list and notify all patients in writing of the requirements of this subsection.

(e) As used in this section:

(i) "Episode of care" means one (1) visit or admission to a health care facility;

(ii) "Insurer" means as defined in W.S. 26-1-102(a)(xvi);

(iii) "Participating provider status" means an express or implied contract between an insurer, or its contractor or subcontractor, and a health care provider in

which the provider has agreed to make specified drugs, devices or services available to a person covered by a private health benefit plan and to receive payment or reimbursement, other than any applicable copayment, coinsurance or other cost sharing requirement, at a rate agreed upon by the insurer and provider.

(f) The department shall adopt rules to implement this section.

Section 2. The department of health shall adopt rules to implement this act on or before July 1, 2019, provided these rules shall not take effect until July 1, 2019.

Section 3.

(a) This act applies to:

(i) Contracts entered into or renewed on or after July 1, 2019; and

(ii) Data generated on or after July 1, 2019.

Section 4.

(a) Section 2 of this act is effective immediately upon completion of all acts necessary for a bill to become law as provided by Article 4, Section 8 of the Wyoming Constitution.

(b) Except as otherwise provided by subsection (a) of this section, this act is effective July 1, 2019.

(END)