

1. INTRODUCTION

1.1 Purpose

The Database of State Laws Impacting Healthcare Cost and Quality (SLIHCQ) is a publicly available interactive tool that catalogues existing and ongoing state legislative efforts to implement healthcare reform. The database aims to help stakeholders at the state level understand their legal and regulatory environment and identify laws that could support their efforts to create a higher-value health care system.

1.2 Support

The SLIHCQ Database was created in May 2019 by [The Source on Healthcare Price & Competition](#) at UC Hastings College of the Law, in partnership with [Catalyst for Payment Reform](#), with the help of a team of health policy researchers and legal scholars from both institutions. [The Robert Wood Johnson Foundation](#) provided the initial funding and support for the project.

2. METHOD

2.1 Key Issue Tagging

The SLIHCQ Database utilizes key issue tagging for each legislation record catalogued in the database for purposes of accurate identification and search results. Statutes and bills often use different language to describe the same type of law. For example, many states have legislation that target [balance billing or surprise billing](#). However, states do not always use the exact same language in their surprise or balance billing legislation, often making it harder to identify the same type of law even when they exist.

The Source's key issue tagging system captures the same type of law by tagging them with the same issue tag, in this case "Surprise Billing or Balance Billing", so that a search would pull up all relevant records, such as Illinois statute 210 Ill. Comp. Stat. § 88/50, which does not include the phrase "surprise billing" or "balance billing" in its statute language.

210 Ill. Comp. Stat. § 88/50. Notification concerning out-of-network providers: Fair Patient Billing Act – Illinois

☑ Status: **Enacted**
📅 Year Enacted: **2007**
📎 File: **Download** 📄

During the admission or as soon as practicable thereafter, the hospital must provide an insured patient with written notice that the patient may receive separate bills for services provided by health care professionals affiliated with the hospital; if applicable, some hospital staff members may not be participating providers in the same insurance plans and networks as the hospital; if applicable, the patient may have a greater financial responsibility for services provided by health care professionals at the hospital who are not under contract with the patient's health care plan; and questions about coverage or benefit levels should be directed to the patient's health care plan and the patient's certificate of coverage.

Key Issues: PRICE AND QUALITY TRANSPARENCY Surprise Billing or Balance Billing Provider Network HEALTHCARE MARKETS

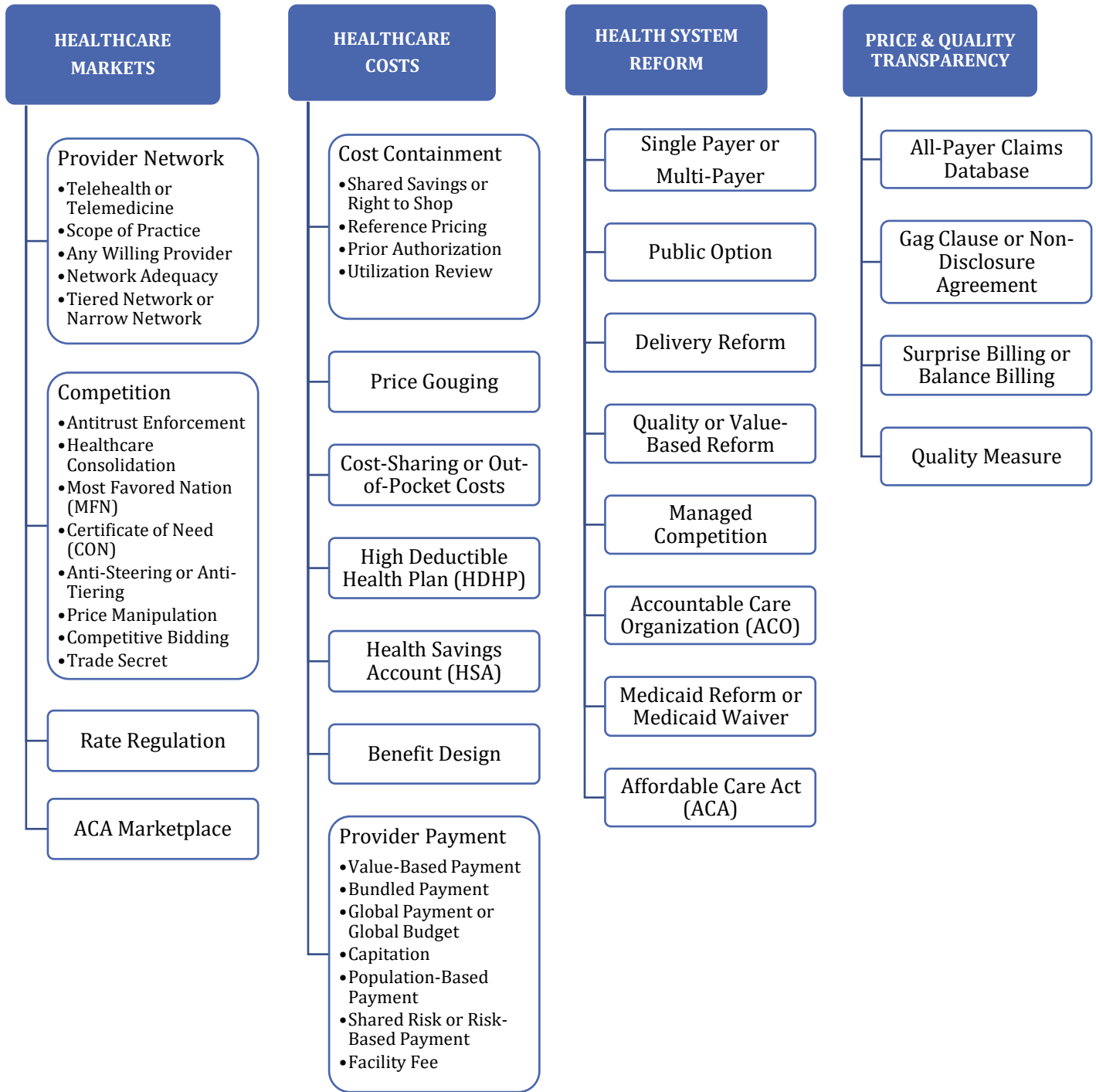
The Source identified four main categories of key issues for the legislation included in the database:

1. Healthcare Markets
2. Healthcare Costs
3. Healthcare System Reform
4. Price and Quality Transparency

Each category further breaks down into subcategories, forming a hierarchical structure in which lower-level key issues are nested within the higher-level issues. For each record tagged with a lower level issue tag, it is automatically also tagged with the higher-level issue tag in which the lower level tag is nested.

The Source Glossary (Appendix 1) provides detailed definitions and examples of each of the key issues for user reference. See the chart on the next page for illustration of the tagging structure. Click on each key issue for definition and example.

(Continued on Next Page)



**See Appendix 1 for a glossary of all key issues with definitions and examples.*

2.2 Scope

While many healthcare laws touch upon the four main categories catalogued in the database, certain topics are tangential to the project and are not included. Specifically,

the database focuses on issues related to competition and market designs in the main provider and payer markets and how these relationships affect healthcare price and quality.

As part of the initial funding for the project, the SLIHCQ Database does not catalogue all enacted laws related to the pharmaceutical market. The Source, however, tracks pharmaceutical bills beginning in the 2017-2018 legislative session, and continues to populate newly enacted pharmaceutical legislation as part of the database. As a result, users should note that pharmaceutical statutes included in the database are not the result of exhaustive searches of all existing laws and therefore not comprehensive in coverage.

The chart below breaks down each of the four main categories by key issue and illustrates what is in scope and included in the database and what is out of scope and not covered in the database.

Category	Definition	In Scope ✓	Out of Scope X
In General	This free database allows the public to search state healthcare laws impacting healthcare costs and quality, specifically in five main categories	Transparency of healthcare prices and quality	Nursing facilities
		Healthcare Competition Laws	Residential treatment
		Anti-competitive practices	Long-term care
		State healthcare reform	Durable medical equipment
		Payment reform	Rehabilitation centers
		Network design	Dental
		Benefit design	Coverage requirements (who to cover, what to cover)
		Definitions or relevant terms	Licensing (e.g., Certificate of Authority to practice medicine)
			Obscure groups of patients
			Access to care

Category	Definition	In Scope ✓	Out of Scope X
Price and Quality Transparency	Statutes related to giving consumers and providers access or preventing them from accessing the price and/or quality of health care services and providers.	Transparency of healthcare prices	Electronic Health Records
		Transparency for healthcare quality	Health Information Technology
		Websites / Public Price or Quality Reports	Health Information Exchange
		All Payer Claims Databases (APCDs)	Patient medical records
		Provider directories	
		Balance billing/ surprise billing	
		Gag clauses	
		Trade secret laws	
		Non-disclosure agreements	
Healthcare Markets	These include provider network laws, competition laws, rate regulation laws, and laws governing the ACA marketplaces. Provider network laws: Statutes that promote methods to drive consumers to high quality, affordable providers and away from low quality, high cost providers or statutes that prevent methods to drive consumers to high quality, affordable providers and away from low-quality, affordable providers. Competition laws: Statutes that promote competition in health care or statutes that are anti-competitive.	Antitrust	Licensing (e.g., COA to practice medicine)
		Gag clauses	Access to care
		Anti-steering/tiering clauses	
		Any willing provider clauses	
		Most favored nation clauses	
		All or nothing clauses	
		Trade secret laws	
		Healthcare consolidation	
		Certificate of Public Advantage	
		Certificate of Need	
		Rate regulation	
		Unfair billing practices	
		Unfair trade practices	
		Network adequacy	
		Telehealth/telemedicine	
		Provider directories	
		Preferred providers	
		Scope of practice	
Tiered network			
Narrow network			
Limited network			
Centers of excellence			

Category	Definition	In Scope ✓	Out of Scope X
Healthcare Costs	<p>While all laws for the database touch upon healthcare costs, laws labeled with this tag do so in a direct manner. They specifically mention pricing, costs, etc. Many fall under general cost containment strategies, but some regulate/reform provider payments or benefit design and pricing.</p> <p>Provider payment laws: Statutes that promote new methods to pay providers that change how care is delivered and/or reward them for quality or statutes that create barriers to tracking quality and/or making providers financially accountable for their patients' care.</p>	Facility fees	Licensing (e.g., Certificate of Authority to practice medicine)
		Payment reform	
		Value-based payment	
		Bundled payment	
		Global payment or global budget	
		Capitation	
		Population-based payment	
		Shared risk or risk-based payment	
		Benefit Design	
		Health Savings Accounts/Health Reimbursement Accounts with High Deductible Health Plans	
Price gouging			
	Cost containment strategies, including utilization review, prior authorization, reference pricing, shared savings, or right to shop		
Health Care System Reform	<p>Statutes that are related to broader health reform efforts, including reform related to the ACA, Medicaid reform or waivers, promotion of Accountable Care Organizations, managed competition, and other models.</p>	Managed competition	Coverage requirements (who to cover, what to cover)
		Value based insurance design	
		Coverage of preventive care	
		Public option	
		Single Payer or Multi-Payer	

3. FUNCTIONALITIES

3.1 Keyword Search

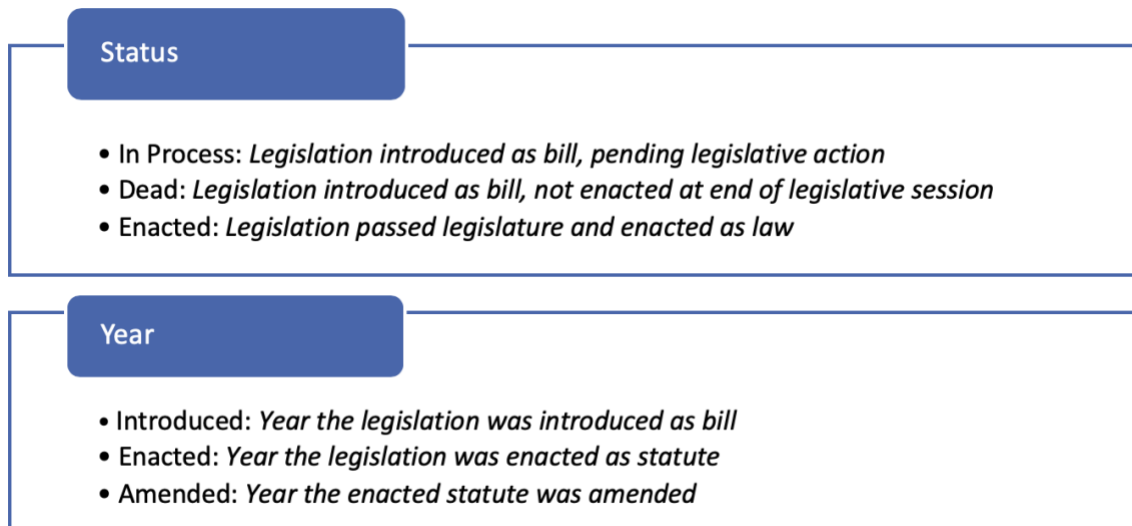
Type in a keyword to search for legislation by title, topic, key issue, or actual language of the enacted law (statutes only). Use keyword search on its own or in combination with other parameters, such as status, key issue, and/or jurisdiction (see Section 3.2).

The screenshot shows a search interface with four main sections: Search, Status, Key Issues, and Jurisdiction. The Search section has a text input field containing "Search all Legislation". The Status section has a dropdown menu with "Enacted" selected. The Key Issues section has four checkboxes: "HEALTHCARE MARKETS", "Provider Network", "Telehealth or Telemedicine" (checked), and "Scope of Practice" (checked). The Jurisdiction section has four checkboxes: "Federal", "Alabama", "Alaska", and "Arizona" (checked). At the bottom left, there are "Submit" and "Reset" buttons.

3.2 Search and Filter by Field

Each record in the SLIHCQ Database contains fields of information that can be toggled to filter and customize searches. Use the filters in combination with a keyword search to narrow down the results by specific criteria or use each field filter independently or in combination with each other without a keyword search to get specific results.

See chart below for details of the type of information each field contains to accurately use each field to filter for desired results.



Jurisdiction

State of the legislation (includes all 50 states and District of Columbia)

Key Issue Tags

Identifies the type of legislation by topic; multiple tagging enabled

3.3 Legislation Language

Each database record provides additional information on the legislation including 1) a short summary, and 2) actual text of the legislation through either the state legislature website (bills) or a PDF file that is available for download (statutes).


Summary

Short description of what the legislation mandates

Legislation Language

- Bill: *Via link to state legislature website bill info page*
- Statute: *Via PDF file available for download from the SLIHCQ Database*

210 Ill. Comp. Stat. § 88/50. Notification concerning out-of-network providers: Fair Patient Billing Act – Illinois

- Status: **Enacted**
- Year Enacted: **2007**
- File: **Download** 

Legislation
Summary

During the admission or as soon as practicable thereafter, the hospital must provide an insured patient with written notice that the patient may receive separate bills for services provided by health care professionals affiliated with the hospital; if applicable, some hospital staff members may not be participating providers in the same insurance plans and networks as the hospital; if applicable, the patient may have a greater financial responsibility for services provided by health care professionals at the hospital who are not under contract with the patient's health care plan; and questions about coverage or benefit levels should be directed to the patient's health care plan and the patient's certificate of coverage.

Key Issues: PRICE AND QUALITY TRANSPARENCY Surprise Billing or Balance Billing HEALTHCARE MARKETS

4. MAINTENANCE & UPDATE

Beyond cataloguing all existing statutes to date, the Database tracks and collects bills of all 50 states and the District of Columbia as introduced in each legislative session. Uploads and updates of bills are ongoing and will occur on a weekly basis throughout each state's legislative term depending on its legislative calendar (refer to each individual state page on [The Source](#)).

At the end of the state's legislative term, all bills introduced during the term will be updated as either "Dead" (legislation not enacted by the end of the term) or "Enacted" (legislation passed legislature and enacted as law). For legislation enacted as law, the database will convert the original legislation record from a bill to a statute upon codification and publication on the state legislature website. The actual codification process and timing varies depending on the state, ranging from weeks to months. The Database will process the conversion of bill to statute for all enacted legislation within one legislative term.

5. FEEDBACK

The SLIHCQ Database is an ongoing project and will continue to improve its content and functionalities to provide the best user experience. User feedback and suggestions are always welcome and appreciated. Please email any technical issues, content errors, and/or functionality suggestions to info@sourceonhealthcare.org.

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HEALTHCARE MARKETS

Laws that are related to oversight of the healthcare markets. These can be laws related to competition (antitrust, mergers, contracting, etc.), provider networks, and ACA marketplace laws. However, these laws must, in some way, touch upon the price, cost, affordability, or quality of healthcare. If a law simply governs a healthcare market but doesn't touch upon price, cost, affordability, or quality, then do not include it.

Example: 20 Ill. Comp. Stat. § 3960/3 et seq. lays out the requirements for acquiring a Certificate of Need for health facilities in Illinois.

Provider Network

Provider network laws are those laws that govern the design and structure of how consumers/patients access providers. For example, a law may require a benefit plan to provide access to certain types of providers (e.g., low cost, high quality) for certain illnesses or may regulate HMOs. These laws fall under Healthcare Markets. They must impact price, cost, affordability, or quality of healthcare in some way.

Example: Massachusetts Gen. L. Ch. 176J, § 15 requires that any insurer offering a tiered network plan, which places providers in different tiers based on their cost and quality performance, to clearly and conspicuously indicate the cost-sharing (e.g., copayment, coinsurance) differences for consumers/patients in the various tiers.

Telehealth or Telemedicine

Any laws that permit or restrict the practice of medicine over the phone, internet, etc. Since telehealth/telemedicine theoretically lowers the cost of healthcare for patients (fewer transportation expenses is just one example), we will track these laws.

Example: New Jersey Stat. Ann. 45:1-62 states that a provider who establishes a relationship with a patient may remotely provide health care services to a patient through the use of telemedicine.

Scope of Practice

Laws that explain who is a provider for the purposes of the practice of medicine, writing prescriptions, etc. A law may give a registered nurse the ability to prescribe medications, for example. Care from alternative providers (e.g., registered nurses, physician's assistants) is often less expensive than care from a physician.

Example: Maine Rev. Stat. Ann. Tit. 32, § 2594-A states that an individual shall not be prohibited from rendering medical services if received from an alternative provider under the supervision of a licensed physician.

Any Willing Provider

"Any Willing Provider" statutes, sometimes referred to as "Any Authorized Provider," are laws that require health insurance carriers to include all health care providers affiliated with a health system or provider group as in network if certain conditions are met.

Example: Maine Rev. Stat. Ann. Tit. 24-a, § 4317 requires health carriers to contract with any pharmacy that meets their terms and conditions for participation in the carrier's network.

Network Adequacy

Somewhat distinguished from "Provider Network" laws (of which "Network Adequacy" is a subcategory), these laws try to promote the adequacy of their healthcare/provider networks so that patients have adequate access to care.

Examples: North Carolina Gen. Stat. Ann. § 58-67-11 states that HMOs in their application must describe how they will ensure patients have adequate access to providers in order to be licensed.

Tiered Network or Narrow Network

Under a narrow network design, consumers/patients have a smaller network of providers from which to receive care in exchange for lower copayments and coinsurance. Unless the service is unavailable from within its own network, an insurer usually pays nothing for care received out-of-network.

What is a Narrow Network?

- Limited provider network
 - Looks a lot like 1990s model HMOs
 - Typically restricted to low-cost providers—less about quality (though can be about quality)
 - Can be part of a tiered network offering
- Insurance exchange products driving narrower networks

Tiered Network

- Providers are placed into tiers based upon total cost of care, pricing or some quality and cost index
- Consumers/Patients have different cost sharing rates (e.g., copayments, coinsurance) for different tiered providers to incentivize them to receive care from lower cost, higher quality providers.

States may attempt to regulate, restrict, or promote a narrow network or tiered network design.

Example: Colorado Rev. Stat. Ann. § 10-16-705.5 states that health carriers should develop standards for the selection of providers, including developing standards for tiering.

Competition

Laws dealing with healthcare competition include antitrust enforcement, unfair trade practices, healthcare consolidation, contracting provisions, establishing requirements for building of healthcare facilities, price manipulation, and promotion of competition in bidding practices, creation of new facilities, and more.

Example: Nev. Rev. Stat. §§ 598.0903 through 598.0999 regulates deceptive trade practices, including those in the healthcare industry.

Antitrust Enforcement

Antitrust enforcement laws are those laws that attempt to prevent or control trusts or other monopolies, with the intention of promoting competition in business. Antitrust enforcement can be done via state, federal, or private actors.

Examples: New York Gen. Bus Law § 340 is the state's general antitrust statute that prohibits "every contract, agreement, arrangement or combination" that establishes or maintains a monopoly that restrains competition.

Healthcare Consolidation

These laws govern mergers, acquisitions, integrations, and joint ventures.

Examples: New York Pub Health Law § 2999-bb states that the department has the authority to set regulations, standards, fees related to proposed collaborations, integrations, mergers or acquisitions of integrated health care delivery systems.

Most Favored Nation (MFN)

A most favored nation clause (also called a "most favored customer clause" or "most favored licensee clause") is a contract provision in which a seller/licensor agrees to give the buyer/licensee the best terms it makes available to any other buyer/licensee. In the healthcare context, an MFN clause typically manifests as a provision within a health network plan contract in which a dominant health plan obtains a promise that the provider (supplier of healthcare services) will not give an equal or more favorable price to any other plan. An MFN clause is variously referred to as a "most favored customer clause," "prudent buyer clause," or

“nondiscrimination clause” because it ensures that the customer or buyer of services will receive the best price from the seller. States may ban these for their anticompetitive effects.

Example: North Carolina Gen. Stat. § 58-50-295 prohibits most-favored nations clauses in a contract between a health insurance carrier and a health care provider.

Certificate of Need (CON)

Some states prohibit entry or expansion of healthcare facilities through “certificate-of-need” (CON) programs. These laws, which require government permission before a facility can expand, offer a new service, or purchase certain pieces of equipment, were enacted in the belief that restricting entry would lower health care costs and increase availability of these services to the poor. These regulations were initially enacted under the theory that unregulated market competition would drive medical providers to overinvest in facilities and equipment, raising the cost of medical care.

Examples: 35 Pennsylvania Stat. and Cons. Stat. § 448.101, et seq. requires permission before a health facility can expand, offer a new service or purchase certain items that may decrease competition.

Certificate of Public Advantage (COPA)

A Certificate of Public Advantage (COPA) is the written approval by a state government which governs a Cooperative Agreement among two or more providers. A state can grant a COPA to a specific entity that states that they will allow and regulate a consolidation/merger even if it would otherwise be antitrust infringing. The goal of the COPA application process is to protect the interests of the public in the region affected.

Examples: Maine Rev. Stat., Tit. 22, §§ 1841-52 creates the Hospital and Health Care Provider Cooperation Act, which supports cooperation among providers, provides for the issuance of certificates of public advantage, and provides an exemption from federal antitrust scrutiny (under the state action doctrine).

Anti-Tiering or Anti-Steering

Insurers employ steering and tiering through narrow and tiered networks to incentivize consumers to use lower-cost providers or provider networks in order to reduce some of their healthcare expenses. Some providers (e.g., health systems) have instituted anti-steering and anti-tiering provisions in contracts with health insurers to prevent them from driving patients to their competition. This practice often allows providers to maintain market power as health insurers cannot offer their patients lower cost options. States have attempted to regulate against this in recent years.

Example: Mass. Gen. Laws ch. 176O, § 9A prohibits agreements or contracts that limit the ability of the insurer to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation.

Price Manipulation

These are laws against price manipulation target price discrimination, price fixing, predatory pricing, etc.

Example: 40 Pa. Cons. Stat. § 471 says that no insurance company, association, or exchange shall offer, promise, allow, give, set off, or pay, directly or indirectly, any rebate of, or part of, the premium payable on the policy.

Competitive Bidding

Laws that promote or inhibit competitive bidding in the healthcare market (such as through mergers and acquisitions or acquiring providers, etc.) can impact healthcare prices.

Example: Cal. Welf. & Inst. Code §§ 14081 through 14087.29 specifies that Medi-Cal’s special negotiator will give selective provider contracts with the state on a competitive bid basis.

Trade Secret

A trade secret is a formula, practice, process, design, instrument, pattern, commercial method, or compilation of information not generally known or reasonably ascertainable by others by which a business can obtain an

economic advantage over competitors or customers. In healthcare, this can be price information, such as pricing for pharmaceuticals, benefit design, etc. States have varying regulations on trade secrets.

Example: North Carolina Gen. Stat. Ann. § 132-1.2 states that nothing in the specified chapter shall be construed to authorize or require disclosure of a trade secret or other confidential information.

Rate Regulation

Rate regulation should be self-explanatory – states regulate rates that providers, insurers, etc. charge. This can include laws that set rates (“rate setting” or the practice that in advance establishes the amount that hospitals will be paid no matter how high or low their costs actually are in any particular year) or that charge the state—usually the State Insurance Commissioner—with reviewing rates (“rate review”).

Example: 42 R.I. Gen. Laws Ann. § 14.5-3, et seq. describes the functions of the state health insurance commissioner, which includes regulation of the health insurance industry in Rhode Island.

ACA Marketplace

With the introduction of the ACA Marketplaces, many state governments became concerned with the pricing of services within these markets. As such, they have passed laws to try to curb spending in these markets/on these plans. In order to qualify for the database, these laws must, in some way, touch upon the price of healthcare. If a law simply governs an ACA marketplace but doesn’t touch upon price, then do not include it.

Example: 42 R.I. Gen. Laws § 42-157-1 establishes Rhode Island’s ACA exchange.

HEALTHCARE COSTS

While all laws for the database touch upon healthcare costs, laws labeled with this tag do so in a direct manner. They specifically mention pricing, costs, affordability, etc. Many fall under general “Cost Containment” strategies, but some regulate provider payments or benefit design and pricing.

Example: 20 Ill. Comp. Stat. § 215/5-1 allows any third-party payor to have the option to require utilization review for hospital admissions and continued hospital stays.

Cost Containment

Cost containment laws attempt to curtail the costs of healthcare through different mechanisms. Some of these strategies include reference pricing, prior authorization, and utilization review.

Example: Cal. Gov. Code §§ 15438.7 & 15438.10 state that it plans to develop new and cost-effective methods of delivering health services utilizing innovative models that can be demonstrated to be effective and then replicated throughout California and that bring community-based health care preventive services to individuals where they live or receive education, social, or general health services

Shared Savings or Right to Shop

PROVIDE DEFINITION

Programs in which an insurer creates an incentive or savings reward program that gives patients financial rewards for choosing providers with lower than average costs. With a right-to-shop program, the insurer typically shares any savings from the choice of a lower-cost provider with the patient, giving the patient a financial incentive to seek a higher-value provider even with a flat co-pay or met deductible. Under a right-to-shop program, when a doctor recommends or prescribes a medical service, the patient would call his insurer or use an on-line tool to compare costs for different providers. The patient can then balance costs, travel distance, and other factors to choose the best treatment location for him.

Example: Under Minn. Stat. § 256B.0754, by July 1, 2010, the commissioner of human services shall implement quality incentive payments as established under section 62U.02 for all enrollees in state health care programs consistent with relevant state and federal statute and rule.

Reference Pricing

A cost containment strategy by which a payer will offer to pay a specific price for a healthcare good or service and providers may either agree to that price or charge more. If they charge more, the patient must pay the difference out of pocket. Payers use reference pricing to steer patients toward lower cost providers, sometimes high value providers. States may regulate the use of reference pricing.

Example: Ga. Code Ann. § 33-64-11 prohibits PBMS from charging or collecting from an insured a copayment that exceeds the total submitted charges by the network pharmacy for which the pharmacy is paid.

Prior Authorization

Prior authorization (PA) is a requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you. PA is a technique for minimizing costs, wherein benefits are only paid if the medical care has been pre-approved by the insurance company. States may either encourage or inhibit/prohibit prior authorization.

Alternatively, prior authorization can refer to the process requiring patients to receive approval—or a referral—from their primary care physician before they can receive coverage for a service from a specialist.

Example: Connecticut Gen. Stat. Ann. § 38a-477aa states that no health plan can require prior authorization for rendering emergency services.

Utilization Review

Utilization review is a health insurance company's opportunity to review a request for medical treatment. The purpose of the review is to confirm that the plan provides coverage for your medical services. It also helps the company minimize costs and determine if the recommended treatment is appropriate. States may either encourage or inhibit/prohibit utilization review.

Example: Maine Rev. Stat. Ann. Tit. 24-a, § 4304 specifies requirements that carriers in the state must abide by if requiring prior authorization of health care services or otherwise subject payment of services to review for clinical necessity, appropriateness, efficacy, or efficiency.

Price Gouging

Price gouging is when a seller spikes the prices of goods, services, or commodities to a level much higher than is considered reasonable or fair, and is considered exploitative, potentially to an unethical extent. Many states ban or inhibit price gouging, though what constitutes price gouging depends on the price and type of service/good.

Example: Fla. Stat. § 636.036 establishes that prepaid limited health service organizations may have to submit a contract, which can be reviewed in order to determine if the fees charged are so high as to be detrimental to subscribers and others.

Cost-Sharing or Out-of-Pocket Costs

In health care, cost sharing occurs when patients pay for a portion of health care costs not covered by health insurance (e.g., copayments, coinsurance). The "out-of-pocket" payment varies among healthcare plans and depends on whether or not the patient chooses to use a healthcare provider who is contracted with the healthcare plan's network. States may cap or regulate these costs.

Example: Under Nev. Rev. Stat. §§ 439B.260 through 439B.28, a major hospital shall not collect or seek to collect the deductible or copayment from a patient who is covered by Medicare and who demonstrates that he or she is medically indigent, as that term is defined for the purposes of Medicaid coverage for persons in long-term care.

High Deductible Health Plan (HDHP)

A high-deductible health plan (HDHP) is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. Being covered by an HDHP is also a requirement for having a health savings account. Some states encourage the use of HDHPs.

Example: Tenn. Code Ann. § 67-10-101 defines state requirements of a high deductible health plan with a health savings account.

Health Savings Account (HSA) or Health Reimbursement Account (HRA)

A health savings account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit.

A health reimbursement arrangement (HRA), commonly referred to as a health reimbursement account, is an IRS-approved, employer-funded, tax-advantaged personalized health benefit that reimburses employees for out-of-pocket medical expenses and individual health insurance premiums.

States regulate both, and many encourage the use of these through their legislation.

Example: Tenn. Code Ann. § 67-10-101 defines state requirements of a high deductible health plan with a health savings account.

Benefit Design

Benefit designs are the way health insurance plans are curated and balanced between costs and coverage. They are a key part of reform efforts; they work in tandem with payment methods to encourage consumers to use the providers that accept new forms of payment and are high-value or to seek services they need to improve their outcomes. Health benefit plans can be designed to reduce barriers to maintaining and improving health (see value-based insurance design). States regulate benefit designs, including mandating certain benefits that are medically necessary or banning exclusions based on pre-existing conditions.

Example: Maine Rev. Stat. Ann. Tit. 24-a, § 4318-A states that a carrier offering a health plan shall establish a benefit design in which enrollees are directly incentivized to shop for low-cost, high-quality participating providers for comparable health services. Incentives may include cash payments, gift cards, credits or reductions in premiums, copayments or deductibles.

Provider Payment

Provider payment laws regulate how providers are paid. They may encourage certain models, such as fee-for-service, pay-for-performance, quality-based payment models, site neutral payments, etc.

Example: 215 Ill. Comp. Stat. § 125/4.5-1 states that HMOs that offer point-of-service contracts must abide by these limitations.

Value-Based Payment

Payment models that are essentially the best bang for your buck. Value-based programs reward health care providers with incentive payments for the quality of care they give to people. Providers, including hospitals and physicians, are paid based on patient health outcomes.

Example: Colo. Rev. Stat. § 25.5-4-401 establishes rules for the payment of providers, that payments should be reasonable. Provider payments may include provisions that encourage the highest quality of medical benefits and the provision of the least expense possible, including the use of capitated payments, assignment of Medicaid recipients in Medicaid managed care to a primary care provider and expectations of providers offering care to such patients.

Bundled Payment

Bundled payment, also known as episode-based payment, episode payment, episode-of-care payment, case rate, evidence-based case rate, global bundled payment, global payment, package pricing, or packaged pricing, is defined as the reimbursement of health care providers (such as hospitals and physicians) "on the basis of expected costs for clinically-defined episodes of care." It has been described as "a middle ground" between fee-for-service reimbursement (in which providers are paid for each service rendered to a patient) and capitation, given that risk is shared between payer and provider.

Example: Tenn. Code Ann. § 71-5-151, describes the state Medicaid agency's development of episodes of care (like bundled payments) and other payment reform initiatives.

Global Payment or Global Budget

A global payment or global budget is a set amount under which the provider group, health system, or hospital system must operate for a given year. The payment or budget is determined prospectively.

Example: Md. Code, Health-Gen. § 16-201.3 governs rates and reimbursement for community health providers whose rates are not regulated by the Health Services Cost Review Commission. The Governor's budget shall include increased funding for the community providers, and the Behavioral Health Administration and the Medical Care Programs Administration jointly shall conduct an independent cost-driven, rate-setting study to set community provider rates for community-based behavioral health services that includes a rate analysis and an impact study that considers the actual cost of providing community-based behavioral health services.

Capitation

Capitation is a fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services.

Example: Colo. Rev. Stat. § 25.5-4-401 establishes rules for the payment of providers, that payments should be reasonable. Provider payments may include provisions that encourage the highest quality of medical benefits and the provision of the least expense possible, including the use of capitated payments.

Population-Based Payment

In a population-based payment arrangement, a provider entity agrees to accept responsibility for the health of a group of patients in exchange for a set amount of money. If the provider effectively manages cost and performs well on quality of care targets, then the provider may keep a portion of the savings generated. However, if the provider delivers inefficient, high-cost care, then depending on the structure of the arrangement, it may be held responsible for some of the additional costs incurred. The goal of this type of payment arrangement is to align the financial incentives of the providers with the interests of the patients and the payers so that everyone wins if patients are healthy and costs are held down. Global payments and shared risk payments can be considered population-based payments.

Example: Under Minn. Stat. § 256B.0755, the commissioner shall continue a demonstration project established under this section to test alternative and innovative integrated health partnerships, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement.

Shared Risk or Risk-Based Payment

As the new ACOs form, payers are establishing shared-savings programs and other payment models in an effort to create financial incentives for high-quality care. Payers are also considering payment methods that confer a portion of the financial risk to the provider, seeking to create stronger incentives than shared savings only.

Shared Risk Payment: Four Approaches ¹		
Risk Model	Definition	Examples
Bonus Payment at Risk	Provider is at risk of not receiving a bonus payment based on quality and/or efficiency performance	- Blue Cross Blue Shield of Minnesota - Preferred One
Market Share Risk	Patients are incentivized by lower copays or premiums to select certain providers so providers are at risk of loss of market share	- Buyers Health Care Action Group
Risk of Baseline Revenue Loss	Built on a fee-for-service “chassis”; providers face a financial or payment loss if they fail to meet certain cost or quality thresholds, and/or if actual costs exceed a target cost	- Blue Cross Blue Shield of Massachusetts AQC - Blue Cross Blue Shield of Illinois–Advocate Health Care
Financial Risk for Patient Population (Whole or Partial)	Providers manage patient treatment costs for all or a designated set of services within a predetermined payment stream and are at risk for costs that exceed payments (e.g., partial/full capitation, global budget)	- State Employees Health Commission (State of Maine) (planned) - Anthem/WellPoint (planned)

Example: Under Minn. Stat. § 256B.0755, the commissioner shall continue a demonstration project established under this section to test alternative and innovative integrated health partnerships, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement.

Facility Fee

A facility fee is sometimes charged when a medical office is owned by a hospital. These fees range greatly depending on the location, reaching up to hundreds of dollars. Some states limit or prohibit these fees.

Example: 23 R.I. Gen. Law § 23-17-61 requires that a hospital provide to a prospective patient, the requested cost estimate of their requested anticipated hospital services within five business days of request and the cost of any facility fee.

¹ This table adapted from Suzanne Delbanco, *Promising Payment Reform: Risk-Sharing with Accountable Care Organizations*, *The Commonwealth Fund* (July 2011).

HEALTHCARE SYSTEM REFORM

For the database, Healthcare System Reform laws are those laws that change the structure of healthcare so that it impacts cost or quality. When people think of “healthcare reform” they usually think of the ACA, but this can be any number of subjects, including moves toward universal healthcare, single payer, quality or value-based reform, ACOs, managed competition, payment reform, etc.

Example: 210 Ill. Comp. Stat. § 3/5 et seq. is intended to foster innovations through the development of demonstration projects to license and study alternative health care delivery systems.

Single Payer or Multi-Payer

Single-payer healthcare is a healthcare system financed by taxes that covers the costs of essential healthcare for all residents, with costs covered by a single public system (hence 'single-payer'). Alternatively, a multi-payer healthcare system is one in which private, qualified individuals or their employers pay for health insurance with various limits on healthcare coverage via multiple private or public sources.

Single-payer systems may contract for healthcare services from private organizations (as is the case in Canada) or may own and employ healthcare resources and personnel (as is the case in the United Kingdom). "Single-payer" describes the mechanism by which healthcare is paid for by a single public authority, not the type of delivery or for whom physicians work, which may be public, private, or a mix of both.

Example: Vt. Stat. Ann. tit. 18, § 9551 creates an All-Payer system where participating health care providers are to be paid by Medicaid, Medicare, and commercial insurance using a common methodology.

Public Option

The public health insurance option, also known as the public insurance option or the public option, is a proposal to create a government-run health insurance agency that would compete with other private health insurance companies within the United States.

Example: W. Va. Code §§ 9-4D-1 through 9 establishes a Medicaid buy-in program for certain individuals with disabilities will assist them in becoming independent of public assistance by enabling them to enter the workforce without fear of losing essential medical care.

Delivery Reform

Over the past several years, the federal government has put billions of dollars into a variety of programs aimed at improving the way health care is delivered. The Affordable Care Act (ACA) authorized a broad agenda of reform projects, including accountable care organizations (ACOs), bundled payments, value-based purchasing, primary care initiatives, and other payment and service delivery models. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 established new ways of paying physicians intended to promote high-quality patient care. The goal of delivery reform efforts is to have continuous improvement in the productivity of the care delivery process, which could slow the pace of rising costs without diminishing the quality of care.

Example: Oregon Rev. Stat. Ann. 414.620 through .628, creates the Oregon Integrated and Coordinated Health Care Delivery System, which is a system of state policies and actions to “make coordinated care organizations accountable for care management and provision of integrated and coordinated health care . . . managed within fixed global budgets, by providing care so that efficiency and quality improvements reduce medical cost inflation.”

Quality or Value-Based Reform

Quality or Value-Based Reform are those laws that target quality or value. For example, they may pay providers based on quality performance, or they could encourage patients to seek care from high quality providers.

Example: 23 R.I. Gen. Laws § 23-17.17-1 states that it is an important public health function to promote quality in the state's health care system by developing a health care quality performance measures and reporting program to guide quality improvement initiatives.

Managed Competition

Managed competition is a purchasing strategy to obtain maximum value for money for employers and consumers. It uses rules for competition, derived from rational microeconomic principles, to reward with more subscribers and revenue those health plans that do the best job of improving quality, cutting cost, and satisfying patients. The “best job” is in the judgment of both the sponsor, armed with data and expert advice, and informed, cost-conscious consumers. The rules of competition must be designed and administered so as not to reward health plans for selecting good risks, segmenting markets, or otherwise defeating the goals of managed competition.

Managed competition occurs at the level of integrated financing and delivery plans, not at the individual provider level. Its goal is to divide providers in each community into competing economic units and to use market forces to motivate them to develop efficient delivery systems.

Managed competition is price competition, but the price it focuses on is the annual premium for comprehensive health care services, not the price for individual services.

Example: California’s Knox-Keene Health Care Service Plan Act of 1975 promotes managed care.

Accountable Care Organization (ACO)

ACOs are groups of doctors, hospitals, and other health care providers, who come together to give coordinated high-quality care to their patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves. The ACA heavily encouraged the proliferation of the ACO model, leading to consolidation amongst providers. States regularly implement laws that regulate, promote, or inhibit ACOs.

Example: Oregon Rev. Stat. Ann. 414.620 through .628, creates the Oregon Integrated and Coordinated Health Care Delivery System, which is a system of state policies and actions to “make coordinated care organizations accountable for care management and provision of integrated and coordinated health care [...] managed within fixed global budgets, by providing care so that efficiency and quality improvements reduce medical cost inflation [...]”

Medicaid Reform or Medicaid Waiver

These laws somehow touch upon reforming the Medicaid program for a particular state. States can apply for program flexibility (through a Medicaid waiver) to test new or existing approaches to financing and delivering Medicaid and CHIP. They can also apply for waivers to provide services through managed care delivery systems or otherwise limit people’s choice of providers.

Example: Wash. Rev. Code § 70.47.250 outlines the guiding principles of a basic health option under its Medicaid program, including adequate payment rates and coverage.

Affordable Care Act (ACA)

When the ACA passed, it reformed healthcare across the United States. It often targeted cost and quality of healthcare, including delivery reform, payment reform, etc. Section 1332 waivers fall under this category; these permit a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.

Example: Wash. Rev. Code § 43.71.070 orders its board to establish a rating system consistent with applicable federal law, for qualified health plans to assist consumers in evaluating plan choices in the exchange.

Federal Reform Effort

These laws attempt to reform the healthcare system at the federal level.

Example: [The Affordable Care Act](#)

PRICE AND QUALITY TRANSPARENCY

In theory, transparency of a provider, insurer, or payer's price and quality information will lead to increased consumer engagement in healthcare shopping, thus lowering prices. States have passed many laws to encourage such comparison shopping, including laws to promote transparency of price information, provider directories, transparency on websites, databases of information, published reports, right to shop programs (which financially incentivize patients to choose the best value providers), and mandate disclosure of price information to consumers upon request.

Example: Maine Rev. Stat. Ann. Tit. 22, § 1718-D states that an out of network provider reimbursed for a surprise bill may not bill an enrollee for health care services beyond the applicable coinsurance, copayment, deductible or other out of pocket costs that would be imposed if the services were rendered by an network provider.

All-Payer Claims Database (APCD)

All-payer claims databases (APCDs, sometimes "all payor" is used) are state databases that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from private and public payers.

Insurers directly report APCD data to states, usually as part of a state mandate. In terms of their capacity to produce price, resource use, and quality information for consumers, APCD data have three potential advantages over other datasets:

- They include information on private insurance that many other datasets do not.
- They include data from most or all insurance companies operating in any particular State, in contrast to some proprietary datasets.
- They include information on care for patients across care sites, rather than just hospitalizations and emergency department visits reported as part of discharge data systems maintained by most States through State governments or hospital associations. They also include large sample sizes, geographic representation, and capture of longitudinal information on a wide range of individual patients.

Example: Colorado Rev. Stat. Ann. § 25.5-1-204 establishes an advisory committee to support and facilitate the reporting of health care cost and quality data to an all-payer claims database (APCD), make recommendations to the APCD, and prepare and file annual reports. The APCD will be made available to the public and state agencies and allow for comparisons across geographies and demographics.

Gag Clause or Non-Disclosure Agreement

Gag clauses forbid providers from telling consumers about cheaper options in healthcare. Sometimes that cheaper option is simply paying out of pocket. Some states prohibit or inhibit these. This issue has become popular lately, especially as they relate to pharmaceutical prices.

Example: Connecticut Gen. Stat. Ann. § 38a-478k states that no contract shall prohibit providers from discussing treatment options and services available in or out of network nor prohibit the provider from disclosing the method the managed care organization uses to pay the provider, if requested by the enrollee.

Surprise Billing or Balance Billing

Balance billing, sometimes also called extra billing, is the practice of a healthcare provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

A surprise medical bill is where charges arise when an insured individual inadvertently receives care from an out-of-network provider.

Example: Maine Rev. Stat. Ann. Tit. 22, § 1718-D states that an out of network provider reimbursed for a surprise bill may not bill an enrollee for health care services beyond the applicable coinsurance, copayment, deductible or other out of pocket costs that would be imposed if the services were rendered by an network provider.

Quality Measure

Generally speaking, laws that make quality information available to consumers/patients when selecting health care provider fall into this category.

Examples: Colorado Rev. Stat. Ann. § 10-16-133 determines that consumers deserve to know the quality and cost of their health care. Establishes a state website to display cost and quality information.