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**MODEL POLICY** | Center for a Healthy America

# Employer Health Claims Transparency Act

## PURPOSE OF THIS ACT

- Between 2004 and 2025, the average annual cost of employer-sponsored health insurance for families at small employers increased 167%, from $9,737 to $26,054.
- Third party administrators (TPAs) and pharmacy benefit managers (PBMs) that administer employers' benefits rarely provide employers with the medical and pharmacy claims data of their workforce. This prevents employers from rooting out waste and fraud that raises costs on workers as well as determining the reasonableness of the fees that an insurer charges, which employers who sponsor health benefits are required to do under the Employee Retirement Income Security Act.
- The Employer Health Claims Transparency Act requires TPAs, PBMs, and other middlemen to provide employers with a detailed itemized receipt for their health plans' medical and pharmacy claims and fees and to disclose the location of where patients received health services (compliant with Health Insurance Portability and Accountability Act requirements).
- By passing this model legislation, states can empower small businesses to evaluate their health plans and effectively manage health care spending, saving their workers' health care dollars.

**Section 1. Title**

This Act shall be named the "Employer Health Claims Transparency Act."

**Section 2. Definitions**

As used in this Act:

**(a).** The term "Commissioner" shall mean the State [Insurance Commissioner/Superintendent].

**(b).** The term "Department" shall mean the State [Department of Insurance/Office of the Insurance Commissioner].

**(c).** The term "Public Employee Health Plan" shall mean a governmental plan as defined by 29 U.S.C. § 1002(32), which is sponsored by this State or any political subdivision of this State, or a health benefits program administered for the benefit of public employees and/or eligible retirees.

**(d).** The term "Health Insurance Issuer" shall mean any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Department, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

**(e).** The term "Group Health Plan" shall mean an employee welfare benefit plan that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise. The term does not include Medicare supplement or accident only, fixed indemnity, limit benefit, credit, dental, vision, specified disease, Tricare supplemental insurance, long-term care or disability income, workers' compensation, or automobile medical payment insurance. The term also does not include a self-insured employee welfare benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. s.1001 et seq.

**(f).** The term "Regulated Health Plan" shall mean [either/both] a Group Health Plan as defined by § 2(x) of this Act, or a Public Employee Health Plan under § 2 (x) of this Act:

**(g).** The term "Covered Service Provider" shall mean a service provider that enters into a contract or arrangement with the Regulated Health Plan and reasonably expects $1,000 or more in compensation, direct or indirect, to be received in connection with providing, delivering, arranging for, paying for, or reimbursing any of the costs of healthcare services pursuant to the contract or arrangement, regardless of whether such services will be performed, or such compensation received, by the covered service provider, an affiliate, or a subcontractor.

*Drafting Note: A state may consider referencing the definition of "Covered Service Provider" as described in 29 USC § 1108(b)(2).*

**(h).** The term "Claims and Encounter Information and Data" shall mean all documents, including electronically stored information containing or including claim files, encounter data, remittance and EFT files, medical records supporting payment information, policy and

contract documents, and all documents or electronically stored information containing information described in 29 U.S.C. § 1185m(a)(1)(B).

**(i).** The term "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, and all related privacy and security regulations as described by the Social Security Act of 1935, Pub. L. 74-271, 42 U.S.C.A. §1320d-9(b)(3).

**(j).** The term "Auditable material(s)" means Claims and Encounter Information and Data, and any documentation supporting claim payments, including medical records.

**(k).** The term "Encounter Data" means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between an employee and Regulated Health Plan that is subject to this Act.

**(l).** The term "Health Care Services" means healthcare related items, products, or services rendered or furnished by a provider within the scope of the provider's license, [certification], or legal authorization for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease. The term includes, without limitation, durable medical equipment, infusion, imaging, hospital, medical, surgical, and pharmaceutical services or products.

**(m).** The term "Health Care Provider" means any person, group, professional corporation, or other organization that is licensed or otherwise authorized in this state to furnish a healthcare service or provides the services of such individuals, groups, corporations, or organization, including but not limited to a medical clinic, a medical group, a home health care agency, a health infusion center, an urgent care center, and an emergent care center.

**(n).** The term "Electronic Remittance Advice" means a digital document that a Health Insurance Issuer or Covered Service Provider sends to a health care provider that supplies information about the payment to the health care provider, including any adjustments to claims and other payments based on factors such as contract agreements, patient benefit coverage, expected copays and coinsurance, and capitation payments.

**(o).** The term "Electronic Funds Transfer" means the electronic message a Health Insurance Issuer or Covered Service Provider sends to a financial institution to order the financial institution to electronically transfer funds to a health care provider's account to pay for health care services.

**(p).** The term "self-insured employee welfare benefit plan" shall mean an employee welfare benefit plan whereby an employer assumes the financial risk for providing

healthcare benefits to its employees and such arrangement is subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. s.1001 et seq.

**Section 3. Required Contract Terms with Covered Service Providers**

**(a). In General.** A Regulated Health Plan shall not enter into, extend, or renew a contract or arrangement with a Health Insurance Issuer or Covered Service Provider to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services to the Regulated Health Plan's employees or their dependents unless the contract or arrangement provides the Regulated Health Plan access to all Claims and Encounter Information and Data, and all documentation supporting claim payments, including medical records and policy documents related to Regulated Health Plan enrollee claims:

**(1).** sufficient to enable the regulated health plan to comply with applicable law and plan terms;

**(2).** sufficient to determine accuracy of payments;

**(3).** which does not unreasonably delay a Regulated Health Plan from accessing all Claims and Encounter Information or Data of its employees or their dependents, and all documentation supporting claim payments related to Regulated Health Plan enrollee claims, including medical records and policy documents longer than 15 days from the date of a request for such information by a Regulated Health Plan to a Health Insurance Issuer;

**(4).** which does not unreasonably limit the volume of claims and encounter information or data, and any documentation supporting claim payments of the regulated health plan's employees or their dependents, including medical records and policy documents related to Regulated Health Plan enrollee claims, which a Regulated Health Plan may access during an audit or pursuant to any request by a Regulated Health Plan to a Health Insurance Issuer for such information or data;

**(5).** which does not unreasonably limit the disclosure of the payment arrangements of the Health Insurance Issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services to the regulated health plan's employees or their dependents, including payment calculations and formulas, quality measures, contract terms, payment amounts, incentive measurement periods, and other payment methodologies;

**(6).** which does not unreasonably limit a Regulated Health Plan's right to select

an auditor to review Auditable Materials or limit audit frequency to less than once per month;

**(7).** which does not unreasonably limit a Regulated Health Plan's audit frequency to less than once per month;

**(8).** which does not unreasonably limit a Regulated Health Plan from accessing claims and encounter information or data;

**(9).** which does not unreasonably limit disclosure of fees charged to a Regulated Health Plan related to administration or claims processing, including renegotiation fees, access fees, or repricing fees;

**(10).** which does not unreasonably limit disclosure of information related to overpayments;

**(11).** which does not unreasonably limit public disclosure of de-identified or aggregate information that a Regulated Health Plan receives from a Health Insurance Issuer or Covered Service Provider under this Act.

**(b).** Any agreement between a Health Insurance Issuer and Covered Service Provider to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services to the Regulated Health plan's employees or their dependents, which does comply with each requirement under Section 3(a) of this Act, is void as against public policy.

**(c). HIPAA Compliance**

**(1).** Health Insurance Issuers and Covered Service Providers shall provide information to Regulated Health Plans in a manner consistent with HIPAA privacy and security rules and regulations.

**(2).** A Regulated Health Plan which receives a disclosure under this Act from a Health Insurance Issuer or Covered Service Provider shall comply with HIPAA privacy regulations in handling such information, regardless of if HIPAA is applicable to the Regulated Health Plan's activities.

**(3).** Nothing in this Act shall be construed to modify HIPAA's data privacy requirements related to the creation, receipt, maintenance, or transmission of protected health information.

**Section 4. Data Standards**

Information made available under this Act shall conform to the following standards:

**(a)** All claims from a health care providers shall be made to a Regulated Health Plan in accordance with transaction standards adopted by regulation under HIPAA, as follows:

> **(1).** Institutional, professional, and dental claims shall be made consistent with ASC X12N 837 format or any subsequent standard under 45 CFR § 162.1102;
>
> **(2).** Pharmacy claims shall be made consistent with the National Council for Prescription Drug Programs or any subsequent standard under 45 CFR § 162.1102;
>
> **(3).** Information made available under this Act that is provided to a Regulated Health Plan shall be unmodified copies of the files sent by the health care provider. In the event that claims are sent by the health care provider, in a physical format, such [files] shall be converted to the appropriate standard electronic format by the Health Insurance Issuer or Covered Service Provider. Such files shall be made accessible to a Regulated Health Plan at no cost to the Regulated Health Plan.

**(b).** All claim payment, electronic funds transfer and electronic remittance advice notices sent by a Health Insurance Issuer or Covered Service Provider under a contract with a Regulated Health Plan to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, shall be made available to a Regulated Health Plan as ASC X12N 835 formatted files in accordance with standards adopted by 45 CFR § 162.1102. Such files shall be unmodified copies of the original information sent by the Health Insurance Issuer or Covered Service Provider to the health care provider. Files shall be accessible at no cost to a regulated health plan.

**(c).** Pricing Methodologies: Any agreement between a Health Insurance Issuers or Covered Service Providers and a Regulated Health Plan to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services include disclosures of all calculation formulae, pricing methodologies, and other information to be used to determine the value of reimbursements.

**(d).** Non-claim Costs: All non-claim costs charged to the regulated health plan shall be itemized and made available in real time via a web portal, an Application Programming Interface (API), and through a downloadable comma-separated values (CSV) file.

**(e).** Daily Batch Access: Health Insurance Issuers and Covered Service Providers shall support secure, automated daily batch delivery of claims, encounters, remittances, and fee files to the plan or its business associates.

**Section 5. Prohibition on Gag Clauses**

**(a).** No agreement between a Regulated Health Plan, a Health Insurance Issuer, and or a Covered Service Provider may contain any provision which unreasonably delays or limits a Regulated Health Plan's access to Claims and Encounter Information and Data as required by this Act.

**(b).** An agreement between a Regulated Health Plan, a Health Insurance Issuer, and or a Covered Service Provider may not prohibit or penalize a Regulated Health Plan for making HIPAA-compliant de-identified or aggregate disclosures of Claims and Encounter Information and Data as required by this Act.

**Section 6. Annual Attestation on Price and Quality Information**

**(a).** All Health Insurance Issuers and Covered Service Providers offering services to Regulated Health Plans shall submit annually to the Department a declaration, under penalty of perjury, warranting that said Health Insurance Issuer or Covered Service Provider compliance with this Act, including a statement attesting:

> **(1).** that the information described in Sections 3 and 4 of this Actis available upon request and is provided to Regulated Health Plans in a timely manner; and
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> **(2).** that no agreement to which said Health Insurance Issuer or Covered Service Provider is party, contains terms which directly or indirectly restrict or delay a Regulated Health Plan from auditing, reviewing, or accessing such information subject to this Act.

**(b).** A Health Insurance Issuer or Covered Service Provider may not delegate submission of a declaration required by part (a) of this section to a third-party.

**(c).** If a Health Insurance Issuer or Covered Service Provider cannot obtain information needed to make such declaration as required by this section, it may instead submit a written statement in lieu of declaration which includes:

> **(1).** An explanation of why said Health Insurance Issuer or Covered Service Provider was unsuccessful in obtaining such information, including whether auditing or access was limited;

**(2).** A description of efforts to remove gag clauses, prohibited by [§] of this Act, from existing agreements to which the Health Insurance Issuer or Covered Service Provider is a party; and

**(d).** The Commissioner may prescribe forms and submission dates under this section by rule.

**Section 7. Enforcement**

**(a).** The Commissioner may assess a civil penalty of up to $10,000 per day per violation against any Covered Service Provider or Health Insurance Issuer for violations of [sections] of this Act, each day constituting a separate offense. For Public Employee Health Plans, the [State Administrator/Public Employees Benefits Board] may impose equivalent penalties on their contractors for violations of [sections] of this Act.

**(b).** The Commissioner may issue cease-and-desist orders and seek injunctive relief, contract reformation, restitution of improperly charged non-claim costs or fees, and require corrective action plans for violations of [sections] of this Act.

**(c).** For repeated or willful violations, the Commissioner may take action against a violator's certificate of authority or license as permitted by [State Insurance Code §…].

**(d).** Whistleblower Protection. A covered service provider or health insurance issuer may not retaliate against any person for good-faith reports or cooperation with the Department consistent with this Act.

**Section 8. Rulemaking**

The Commissioner shall promulgate rules to implement Sections 3 through 7 pursuant to [State APA], which shall include adoption of uniform templates and security standards consistent with HIPAA and federal transaction standards for Health Insurance Issuers and Covered Service Providers to transmit information required under this Act to Regulated Health Plans."

**Section 9. Severability**

If any provision of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

**Section 10. Effective Date**

This Act shall be effective for contracts entered, extended, or renewed on or after [insert date].