ESSB 6228 - H COMM AMD
By Committee on Health Care & Wellness

ADOPTED AS AMENDED 03/07/2014

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** Consumers face a challenge finding reliable, consumer friendly information on health care pricing and quality. Greater transparency of health care prices and quality leads to engaged, activated consumers. Research indicates that engaged and educated consumers help control costs and improve quality with lower costs per patient, lower hospital readmission rates, and the use of higher quality providers. Washington is a leader in efforts to develop and publish provider quality information.

Although data is available today, research indicates the existing information is not user friendly, consumers do not know which measures are most relevant, and quality ratings are inconsistent or nonstandardized. It is the intent of the legislature to ensure consumer tools are available to educate and engage patients in managing their care and understanding the costs and quality.

NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW to read as follows:

(1) There is created a performance measures committee, the purpose of which is to identify and recommend standard statewide measures of health performance to inform public and private health care purchasers and set benchmarks to track costs and improvements in health outcomes.

(2) Members of the committee must include representation from state agencies, small and large employers, health plans, patient groups, consumers, academic experts on health care measurement, hospitals, physicians, and other providers. The governor shall appoint the members of the committee, except that a statewide association representing hospitals may appoint a member representing hospitals and a statewide association representing physicians may appoint a member

representing physicians. The governor shall ensure that members represent diverse geographic locations and both rural and urban communities. The committee must be chaired by the director of the authority.

(3) The committee shall develop a transparent process for selecting performance measures, and the process must include opportunities for public comment.

(4) By January 1, 2015, the committee shall submit the performance measures to the authority. The measures must include dimensions of:

(a) Prevention and screening;

(b) Effective management of chronic conditions;

(c) Key health outcomes;

(d) Care coordination and patient safety; and

(e) Use of the lowest cost, highest quality care for acute conditions.

(5) The committee shall develop a measure set that:

(a) Is of manageable size;

(b) Gives preference to nationally reported measures and, where nationally reported measures may not be appropriate, measures used by the health benefit exchange and state agencies that purchase health care;

(c) Focuses on the overall performance of the system, including outcomes and total cost;

(d) Is aligned with the governor's performance management system measures and common measure requirements specific to medicaid delivery systems under RCW 70.320.020 and 43.20A.895;

(e) Considers the needs of different stakeholders and the populations served; and

(f) Is usable by multiple payers, providers, hospitals, purchasers, public health, and communities as part of health improvement, care improvement, provider payment systems, benefit design, and administrative simplification for providers and hospitals.

(6) State agencies shall use the measure set developed under this section to inform purchasing decisions and set benchmarks.

(7) The committee shall establish a public process to periodically evaluate the measure set and make additions or changes to the measure set as needed.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Each carrier offering or renewing a health benefit plan on or after January 1, 2016, must offer member transparency tools with certain price and quality information to enable the member to make treatment decisions based on cost, quality, and patient experience. The transparency tools must aim for best practices and, at a minimum:

(a) Must display cost data for common treatments within the following categories:

(i) In-patient treatments;

(ii) Outpatient treatments;

(iii) Diagnostic tests; and

(iv) Office visits;

(b) Recognizing integrated health care delivery systems focus on total cost of care, carrier's operating integrated care delivery systems may meet the requirement of (a) of this subsection by providing meaningful consumer data based on the total cost of care. This subsection applies only to the portion of enrollment a carrier offers pursuant to chapter 48.46 RCW and as part of an integrated delivery system, and does not exempt from (a) of this subsection coverage offered pursuant to chapter 48.21, 48.44, or 48.46 RCW if not part of an integrated delivery system;

(c) Are encouraged to display the cost for prescription medications on their member web site or through a link to a third party that manages the prescription benefits;

(d) Must include a patient review option or method for members to provide a rating or feedback on their experience with the medical provider that allows other members to see the patient review, the feedback must be monitored for appropriateness and validity, and the site may include independently compiled quality of care ratings of providers and facilities;

(e) Must allow members to access the estimated cost of the treatment, or the total cost of care, as set forth in (a) and (b) of this subsection on a portable electronic device;

(f) Must display options based on the selected search criteria for members to compare;

(g) Must display the estimated cost of the treatment, or total cost

of the care episode, and the estimated out-of-pocket costs of the treatment for the member and display the application of personalized benefits such as deductibles and cost-sharing;

(h) Must display quality information on providers when available; and

(i) Are encouraged to display alternatives that are more cost-effective when there are alternatives available, such as the use of an ambulatory surgical center when one is available or medical versus surgical alternatives as appropriate.

(2) In addition to the required features on cost and quality information, the member transparency tools must include information to allow a provider and hospital search of in-network providers and hospitals with provider information including specialists, distance from patient, the provider's contact information, the provider's education, board certification and other credentials, where to find information on malpractice history and disciplinary actions, affiliated hospitals and other providers in a clinic, and directions to provider offices and hospitals.

(3) Each carrier offering or renewing a health benefit plan on or after January 1, 2016, must provide information regarding cost and quality performance. The information must:

(a) Be prominently displayed on the carrier's web site alongside other consumer tools; and

(b) Include performance information from the following cost and quality performance measurement programs or indicate that the carrier does not participate in the program:

(i) The national business coalition on health performance measures, with scores and comparisons with national and regional benchmarks;

(ii) The national committee for quality assurance quality compass, with Washington state rankings for the prior three years;

(iii) National committee for quality assurance accreditation, with the report card on plan type, overall accreditation status, and star rating; and

(iv) The carrier's medicare five-star rating if the carrier participates in medicare advantage.

(4) The insurance commissioner must prepare a brief, standardized statement for each cost and quality program described in subsection (3)

of this section to explain how consumers may use the information to make cost and quality comparisons. The statement must be displayed with the information required by subsection (3) of this section.

(5) Each carrier offering or renewing a health benefit plan on or after January 1, 2016, must, within thirty days from the offer or renewal date, attest to the office of the insurance commissioner that the member transparency tools meet the requirements in this section and access to the tools is available on the home page within the health plan's secured member web site."

Correct the title.

EFFECT: (1) Establishes a performance measures committee to identify and recommend standard statewide measures of health performance. Provides that the committee is chaired by the Director of the Health Care Authority (HCA). Directs the Governor and statewide associations representing hospitals and physicians to appoint members to the committee. Requires that committee members represent diverse geographic locations and rural and urban communities, as well as state agencies, small and large employers, health plans, patient groups, consumers, academic experts, hospitals, physicians, and other providers.

(2) Requires the committee to develop a transparent process to select performance measures, including an opportunity for public comment. Requires the committee to submit measures to the HCA by January 1, 2015. Specifies what the measures must include (e.g., dimensions of prevention and key health outcomes).

(3) Requires the committee to develop a measure set that: (a) Is of a manageable size; (b) gives preference to nationally reported measures and, when those may not be appropriate, measures used by the Health Benefit Exchange and state agencies; (c) focuses on overall performance of the system; (d) is aligned with the Governor's performance management system measures and common measure requirements specific to Medicaid delivery systems; (e) considers needs of different stakeholders and populations; and (f) is usable by multiple payers, providers, purchasers, and communities.

(4) Requires the committee to establish a public process to periodically evaluate and make additions or changes to the measure set.

(5) Requires state agencies to use the measure set to inform purchasing decisions and set benchmarks.

(6) Requires carriers to display cost data for diagnostic tests (rather than diagnostic treatments). Maintains the requirement that transparency tools be accessible on a portable electronic device, but deletes the requirement that they be accessible while sitting in the doctor's office. Requires the tools to: Allow hospital searches of in-network hospitals; include where to find information on malpractice history and disciplinary actions (rather than the malpractice history

and disciplinary actions themselves); and provide directions to provider officers and hospitals (rather than provide maps and driving directions).

(7) Requires carriers that offer or renew a health benefit plan on or after January 1, 2016, to prominently display information on cost and quality performance on the carrier's web site alongside other consumer tools. Requires the carrier to include performance information for the following programs or indicate the carrier does not participate in the program: The National Business Coalition on Health performance measures, with scores and comparisons with national and regional benchmarks; the National Committee for Quality Assurance quality compass and accreditation, with Washington rankings for the prior three years, report card on plan type, overall accreditation status, and star rating; and the carrier's Medicare five-star rating if the carrier participates in Medicare Advantage. Requires the Insurance Commissioner to prepare a brief statement for each of these programs to explain to consumers how to use the information to make comparisons, and requires the statement to be displayed with the cost and quality performance information.

(8) Removes the restriction on rulemaking by the Office of the Insurance Commissioner.

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