2022 Regular Session

HOUSE BILL NO. 882

BY REPRESENTATIVE ROBERT OWEN

INSURANCE/HEALTH: Enacts the Louisiana Right to Shop Act

AN ACT

To enact Subpart C-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1081 through 1088, relative to costs of healthcare services and procedures for consumers; to enact the Louisiana Right to Shop Act; to require a program with healthcare shopping capabilities and decision support services; to require an interactive marketplace disclosing the costs of certain healthcare services and procedures; to provide for definitions; to provide for incentives; to require reporting; to provide for rulemaking; to provide for effectiveness; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Subpart C-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1081 through 1088, is hereby enacted to read as follows:

SUBPART C-1. THE LOUISIANA RIGHT TO SHOP ACT

§1081. Short title

This Subpart shall be known and may be cited as the "Louisiana Right to Shop Act".

§1082. Definitions

As used in this Subpart, the following definitions apply:

(1) "Allowed amount" means the contractually agreed upon payment amount between a health insurance issuer and a healthcare entity participating in the health insurance issuer's network, excluding any member deductible, copayment, or other obligation.

(2) "Commissioner" means the commissioner of insurance.

(3)(a) "Comparable healthcare service" includes but is not limited to the following:

(i) Radiology and imaging services.

(ii) Laboratory services.

(iii) Infusion therapy.

(b) For purposes of this Subpart, "comparable healthcare service" does not include radiology and imaging or laboratory services in connection with the delivery of chiropractic or orthopedic healthcare services.

(4) "Department" means the Department of Insurance.

(5) "Health benefit plan" has the same meaning as provided in R.S. 22:1020.1.

(6) "Healthcare entity" means both of the following:

(a) A healthcare facility as defined in R.S. 22:1020.1.

(b) A healthcare provider as defined in R.S. 22:1020.1.

(7) "Health insurance issuer" or "issuer" has the same meaning as provided in R.S. 22:1061.

(8) "Shopping and decision support program" means the program established by a health insurance issuer pursuant to the provisions of this Subpart that provides healthcare shopping capabilities and decision support services for enrollees.

§1083. Program implementation; incentives; costs; required reporting

A.(1) A health insurance issuer, hereinafter referred to as "issuer", offering a health benefit plan in this state shall implement a shopping and decision support program that provides shopping capabilities and decision support services for enrollees in a health benefit plan. An issuer may provide incentives for enrollees in

a health benefit plan who elect to receive a comparable healthcare service from a network provider that is both of the following:

(a) Covered by the health benefit plan.

(b) Paid less than the average allowed amount paid by the issuer to network providers for that comparable healthcare service before and after an enrollee's out-of-pocket limit has been met.

(2) The shopping and decision support program may provide each enrollee with at least fifty percent of the issuer's saved costs for each comparable healthcare service; however, the shopping and decision support program may exclude incentive payments, credits, or reductions for services where the savings to the issuer is fifty dollars or less.

(3) Incentives may be calculated as a percentage of the difference between the actual amount paid by the issuer for a given comparable healthcare service and the average allowed amount for that service. Incentives may be provided as a cash payment to the enrollee, a credit toward the enrollee's annual in-network deductible and out-of-pocket limit, a credit or reduction of a premium, a copayment, cost sharing, or a deductible.

(4) The average allowed amount shall be based on the actual allowed amounts paid to network providers under the enrollee's health benefit plan within a reasonable time frame, not to exceed one year.

(5) Annually, at enrollment or renewal, an issuer shall provide, at a minimum, notice to enrollees of the right to obtain information described in Paragraph (4) of this Subsection, the process for obtaining the information, and a description of how to earn any incentives. An issuer shall provide this notice on the issuer's website and in health benefit plan materials provided to enrollees.

B. Notwithstanding the provisions of this Subpart, the total value of incentives offered to any one enrollee shall not exceed five hundred ninety-nine dollars in any calendar year.

C. An issuer shall make the shopping and decision support program available as a component of all health benefit plans offered by the issuer in this state.

D. Prior to offering the shopping and decision support program to any enrollee, an issuer shall file with the department a description of the shopping and decision support program established by the issuer pursuant to the provisions of this Subpart. The issuer has discretion as to the appropriate format for providing the information required and may customize the format to provide the most relevant information necessary to permit the department to determine compliance. The department may review the filing made by the issuer to determine if the issuer's shopping and decision support program complies with the provisions of this Section.

E.(1) An issuer shall annually file with the department for the most recent calendar year the total number of comparable healthcare service incentive payments made pursuant to the provisions of this Section, the use of comparable healthcare services by category of service for which comparable healthcare service incentive payments were made, the total incentive payments made to enrollees, the average amount of incentive payments made by service for the transactions, and the total number and percentage of the issuer's enrollees that participated in the transactions.

(2) Annually, on or before April first, the commissioner shall submit an aggregate report for all issuers filing the information required by this Subsection to the House Committee on Insurance and the Senate Committee on Insurance. The commissioner may set reasonable limits on the annual reporting requirements on issuers to focus on the more popular comparable healthcare services.

§1084. Interactive services for enrollees; out-of-pocket cost estimates

A.(1) An issuer offering a health benefit plan in this state shall comply with the provisions of this Section.

(2) On and after December first, an issuer offering a health benefit plan in this state shall make available the interactive member portal described in Subsection B of this Section, and may make available the toll-free phone number described in Subsection B of this Section.

B.(1) An issuer shall make available an interactive member portal or a toll-free phone number that enables an enrollee to request and obtain from the issuer information on out-of-pocket costs to the enrollee for the comparable healthcare services or on the average payments made by the issuer to network entities or providers for comparable healthcare services, as well as quality data for those providers, to the extent available.

(2) The member portal or toll-free phone number shall allow an enrollee seeking information about the cost of a particular healthcare service to estimate out-of-pocket costs applicable to that enrollee and compare the average allowed amount paid to a network provider for the procedure or service under the enrollee's health benefit plan within a reasonable time frame, not to exceed one year.

(3) The out-of-pocket estimate shall be a good faith estimate based on the information provided by the enrollee or the enrollee's provider of the amount the enrollee will be responsible to pay out-of-pocket for a proposed nonemergency procedure or service that is determined by the issuer to be a medically necessary covered benefit from an issuer's network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the issuer at the time the request is made, and subject to further medical necessity review by the issuer. An issuer may contract with a third-party vendor to comply with the provisions of this Subsection.

(4) An issuer shall provide the information described in this Subsection by the issuer's member portal or toll-free phone number, even if the enrollee requesting the information has exceeded the enrollee's deductible or out-of-pocket costs according to the enrollee's health benefit plan. Existing transparency mechanisms or programs that estimate out-of-pocket costs for enrollees still within their deductible qualify, pursuant to this Section, as long as those mechanisms or programs continue to disclose the estimated average allowed amount, even after an enrollee has exceeded the enrollee's deductible as well as any estimated out-of-pocket costs.

C. Nothing in this Section prohibits an issuer from imposing cost-sharing requirements disclosed in the enrollee's policy, contract, or certificate of coverage for unforeseen healthcare services that arise out of the nonemergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

D. An issuer shall notify an enrollee that the provided costs are estimated costs, and that the actual amount the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed nonemergency procedure or service.

§1085. Comparison of comparable service

At the request of a patient, a healthcare provider shall provide a copy of an order for a comparable healthcare service within two business days of the request.

§1086. Reporting requirements

On or before January first, the department shall publish a report on examples of shared savings incentive programs in other states that directly incentivize current enrollees and retirees to shop for lower cost care. The department shall provide the report in writing to the House Committee on Insurance and the Senate Committee on Insurance to consider the findings in implementation of a statewide shopping and decision support program. The department may implement the program as part of the next open enrollment period if it is believed to be cost effective.

§1087. Rulemaking authority

The commissioner may promulgate rules as necessary to implement the provisions of this Subpart. The rules shall be promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

§1088. Exclusions

Notwithstanding any state-mandated health benefits, this Subpart does not apply to any plan described in Section 1251 of the federal Patient Protection and Affordable Care Act of 2010, P.L. 111-148 and Section 2301 of the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152.

Section 2. Except R.S. 22:1083(E), 1084(A)(2), 1086, and 1087 as enacted by Section 1 of this Act, the provisions of this Act shall become effective on January 1, 2023, and shall apply to all health benefit plans entered into or renewed on or after that date.

Section 3. The provisions of R.S. 22:1083(E) and 1084(A)(2) as enacted by Section 1 of this Act shall become effective on January 1, 2024.

Section 4. The provisions of R.S. 22:1086 and 1087 as enacted by Section 1 of this Act shall become effective on August 1, 2022.

Section 5. The report prescribed in R.S. 22:1086 as enacted by Section 1 of this Act shall be submitted on or before January 1, 2023.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 882 Original 2022 Regular Session Robert Owen

Abstract: Creates the La. Right to Shop Act, including an interactive marketplace for consumers seeking health care.

Proposed law defines "allowed amount", "commissioner", "comparable healthcare service", "department", "health benefit plan", "healthcare entity", "health insurance issuer", and "shopping and decision support program".

Proposed law requires insurance companies offering health benefit plans in the state of La. to offer a "shopping and decision support program", hereinafter "program", for enrollees seeking healthcare services in this state. Further requires an issuer to make the program available as a component of all health benefit plans offered by the issuer in this state.

Annually, at enrollment or renewal, proposed law requires an issuer to provide notice to enrollees of the right to obtain information about the actual amounts paid to network providers for services or procedures the enrollees may receive, as well as a description of how an enrollee can earn incentives for electing to receive comparable healthcare services from a network provider under certain circumstances.

Proposed law allows the program to provide each enrollee with at least 50% of the issuer's saved costs for each comparable healthcare service. Further allows the program to exclude incentive payments, credits, or reductions for services where the savings to the issuer is $50.00 or less.

Proposed law requires the average allowed amount to be based on the actual allowed amounts paid to network providers under the enrollee's health benefit plan within a reasonable time frame, not to exceed 1 year.

Proposed law prohibits the total value of incentives offered to an enrollee from exceeding $599.00 in any calendar year.

Prior to offering the program to any enrollee, proposed law requires an issuer to file with the La. Dept. of Insurance (LDI) a description of the program established by the issuer. Authorizes the issuer to exercise discretion as to the appropriate format for providing the required information. Further authorizes LDI to review the issuer's filing to determine if the issuer's program complies with the provisions of proposed law.

Proposed law requires an issuer to annually file with LDI, for the most recent calendar year, the total number of comparable healthcare service incentive payments made pursuant to proposed law, the use of comparable healthcare services by category of service for which comparable healthcare service incentive payments were made, the total incentive payments made to enrollees, the average amount of incentive payments made by service for the transactions, and the total number and percentage of an issuer's enrollees that participated in the transactions.

By April 1 of each year, proposed law requires the commissioner to submit an aggregate report for all issuers filing the information required by proposed law to the House and Senate committees on insurance. Authorizes the commissioner to set reasonable limits on the annual reporting requirements on issuers to focus on more popular comparable healthcare services.

By December 1, 2024, proposed law requires an issuer to make available an interactive member portal or a toll-free phone number that enables an enrollee to request and obtain from the issuer information on out-of-pocket costs to the enrollee for comparable healthcare services, or the average payments made by the issuer to network entities or providers for comparable healthcare services.

Proposed law does not prohibit an issuer from imposing cost-sharing requirements disclosed in the enrollee's policy, contract, or certificate of coverage for unforeseen healthcare services that arise out of a nonemergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

Proposed law requires an issuer to notify an enrollee that the provided costs are estimated costs, and that the actual amount the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed nonemergency procedure or service.

Proposed law requires a healthcare provider to provide a patient with a copy of an order for a comparable healthcare service within 2 business days of the patient's request.

By January 1, 2023, proposed law requires LDI to publish a report with examples of out-of-state shared savings incentive programs that directly incentivize enrollees and retirees to shop for lower cost care. Requires findings of the report to be used toward implementation of a statewide shopping and decision support program. Authorizes LDI to implement such a program as part of the next open enrollment period if it is believed to be cost effective. Requires LDI to share the report in writing to the House and Senate committees on insurance.

Proposed law authorizes the commissioner to promulgate rules as necessary to implement proposed law in accordance with the APA.

Proposed law does not apply to any plan described in certain sections of the federal Patient Protection and Affordable Care Act or the federal Health Care and Education Reconciliation Act.

Effective Jan. 1, 2023.

(Adds R.S. 22:1081-1088)