SECOND REGULAR SESSION

HOUSE BILL NO. 1659

99TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE EGGLESTON.

5393H.02I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to comparable health care service incentive programs, with a delayed effective date.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Chapter 376, RSMo, is amended by adding thereto one new section, to be known as section 376.2024, to read as follows:

376.2024. 1. This section shall be known and may be cited as the "Missouri Right to Shop Act".

2. As used in this section, the following terms mean:

(1) "Allowed amount", the contractually agreed upon amount paid by a health carrier to a health care provider participating in the carrier's network;

(2) "Average", arithmetic mean;

(3) "Comparable health care service", any covered nonemergency health care service or bundle of services. The director may limit what is considered a comparable health care service if a carrier can demonstrate allowed amount variation among in-network providers is less than fifty dollars.

(4) "Director", the director of the department of insurance, financial institutions and professional registration;

(5) "Health care provider" or "provider", as defined in section 376.1350;

(6) "Health carrier" or "carrier", as defined in section 376.1350 and including without limitation the Missouri consolidated health care plan established in chapter 103 and any other entity offering coverage in this state that is subject to the requirements of the federal Patient Protection and Affordable Care Act, P.L. 111-148;

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

(7) "Program", the comparable health care service incentive program established by a health carrier pursuant to this section;

3. (1) Unless a waiver has been granted as provided in subsection 6 of this section, a health carrier shall develop and implement a program that provides incentives for enrollees in a health plan who elect to receive comparable health care services that are covered by the plan from providers that charge less than the average allowed amount paid by that carrier to in-network providers for those comparable health care services.

(2) Incentives may be calculated as a percentage of the difference between the allowed amount and the average allowed amount for that service, as a flat dollar amount, or by another reasonable methodology approved by the director. The health carrier shall provide the incentive as a cash payment to the enrollee, or as credit toward the enrollee's annual in-network deductible and out-of-pocket limit. Health carriers may allow enrollees to choose how the incentive is provided.

(3) The incentive program shall provide enrollees with not less than fifty percent of the health carrier's saved costs for each service or category of comparable health care service resulting from shopping by enrollees, except that, a health carrier shall not be required to provide an incentive payment or credit to an enrollee when the carrier's saved cost is twenty- five dollars or less.

(4) A health carrier shall base the average allowed amount for a health care procedure or service on the average paid to in-network providers for the procedure or service under the enrollee's health plan within a reasonable time frame not to exceed one year, except that, a health carrier may utilize an alternate reasonable methodology for calculating the average price if approved by the director. A health carrier shall, at a minimum, inform enrollees of their ability to and the process for requesting the average allowed amount for a procedure or service both on their website and in benefit plan material.

4. A health carrier shall make the incentive program available as a component of all health plans offered by the health carrier in this state. Annually at enrollment or renewal, a health carrier shall provide notice about the availability of the program to any enrollee who is enrolled in a health plan eligible for the program.

5. A comparable health care service incentive payment made by a health carrier in accordance with this section shall not be considered an administrative expense of the health carrier for rate development or rate filing purposes.

6. Prior to offering the program to any enrollee, a health carrier shall file with the director a description of the program established by the health carrier pursuant to this section or a request for waiver of the requirements of this section in a manner prescribed

by the director. The director may review the filing made by the health carrier to determine whether the health carrier's program complies with the requirements of this section. Filings made pursuant to this subsection, including any supporting documentation, are confidential until the filing has been granted or denied by the director.

7. A health carrier shall annually file with the director, for the most recent calendar year, the total number of comparable health care service incentive payments made pursuant to this section, the use of comparable health care services by category of service for which comparable health care service incentives are available, the total payments made to enrollees, the average amount of incentive payments made by service for such transactions, the total savings achieved below the average allowed amount by service for such transactions, and the total number and percentage of a health carrier's enrollees that participated in such transactions. Beginning April 1, 2019, and annually by April first of each year thereafter, the director shall submit an aggregate report for all carriers filing the information required by this section to the legislative committees having jurisdiction over health insurance matters. The director may set reasonable limits on the annual reporting requirements on health carriers in order to focus on the comparable health care services for which incentive payments are most frequently paid.

8. (1) A health carrier shall establish an interactive mechanism on its publicly accessible website that enables an enrollee to request and obtain from the health carrier, or a designated third-party, information on the payments made by the health carrier to in-network entities and providers for comparable health care services, as well as quality data for those providers, to the extent available. The interactive mechanism shall allow an enrollee seeking information about the cost of a particular health care service to compare allowed amounts among in-network providers, estimate out-of-pocket costs applicable to that enrollee's health plan, and the average paid to a network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed one year. The out-of-pocket estimate shall provide a good faith estimate of the amount the enrollee shall be responsible to pay out-of-pocket for a proposed nonemergency procedure or service that is a medically necessary covered benefit from a health carrier's in-network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the health carrier at the time the request is made. A health carrier may contract with a third-party vendor to satisfy the requirements of this subdivision.

(2) Nothing in this section shall prohibit a health carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen

health care 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.

(3) A health carrier shall notify an enrollee that these are estimated costs, and that the actual amount the enrollee shall be responsible to pay may vary due to unforeseen services that arise out of the proposed non-emergency procedure or service.

9. (1) If an enrollee elects to receive a covered health care service from an out-of-network provider at a price that is the same or less than the average that an enrollee's health carrier pays for that service to health care providers within its provider network within a reasonable timeframe not to exceed one year, the health carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's price, and upon request of the enrollee shall apply the payments made by the enrollee for that health care service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the health care services had been provided by an in-network provider. The health carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of submitting proof of payment to an out-of-network provider for purposes of administering this section.

(2) A health carrier may base the average paid to in-network providers on what that carrier pays to providers in the network applicable to the enrollee's specific health plan, or across all of their plans offered in this state. A health carrier shall, at a minimum, inform enrollees of their ability to and the process of requesting the average allowed amount for a procedure or service both on their website and in benefit plan material.

10. (1) If a patient or prospective patient is covered by insurance, a health care provider within the health carrier's network shall provide a patient or prospective patient, within two working days, based on the information available to the health care provider at the time, sufficient information regarding the proposed nonemergency admission, procedure, or service for the patient or prospective patient to receive a cost estimate from their health carrier to identify out-of-pocket costs which could be through an applicable toll-free number, website, or access to a third-party service that meets the requirements of this section. A health care provider may assist a patient or prospective patient in using a carrier's toll-free number, website, or third-party service.

(2) If a health care provider is unable to quote a specific amount under subdivision (1) of this subsection in advance due to the health care provider's inability to predict the specific treatment or diagnostic code, the health care provider shall disclose what is known for the estimated amount for a proposed nonemergency admission, procedure, or service, including the amount for any facility fees required. A health care provider shall disclose

the incomplete nature of the estimate and inform the patient or prospective patient of their ability to obtain an updated estimate once additional information is determined.

(3) Prior to a nonemergency admission, procedure, or service, and upon request by a patient or prospective patient, a health care provider outside the patient's or prospective patient's insurer network shall disclose within two working days the amount that shall be charged for the nonemergency admission, procedure, or service, including the amount for any facility fees required.

(4) Health care providers shall post in a visible area notification of the ability for patients and prospective patients with individual or small group health insurance to obtain a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow a health carrier to assist the patient or prospective patient in comparing out-of-pocket and allowed amounts paid for their care to different providers for similar services. This notification shall inform patients and prospective patients of their right to obtain services from different health care providers regardless of a referral or recommendation from an in-network health care provider and that seeking a lower-cost health care provider may result in an incentive to the patient if they follow the steps set by their health carrier. The notification shall outline the parameters of potential incentives approved pursuant to this section. It shall also notify the patient or prospective patient that their health carrier is required to provide enrollees an estimate of out-of-pocket costs and allowed amounts paid for their care to different providers for similar services via a toll-free telephone number and health care price transparency tool. A health care provider may provide additional information in any form to inform patients and prospective patients of carrier-specific price transparency tools or toll-free phone numbers.

11. The director of the department of insurance, financial institutions and professional registration may promulgate rules as necessary to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

12. The board of trustees of the Missouri consolidated health care plan shall conduct an analysis no later than January 1, 2020, of the cost effectiveness of implementing

an incentive-based program for current enrollees and retirees. Any program found to be cost effective shall be implemented as part of the next open enrollment. The Missouri consolidated health care plan shall communicate the rationale for its decision to relevant legislative committees in writing.

Section B. Section A of this act shall become effective January 1, 2019.

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