FIRST REGULAR SESSION

HOUSE BILL NO. 125

99TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE FREDERICK.

0285H.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapter 103, RSMo, by adding thereto one new section relating to the right to shop act, with a delayed effective date.

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

Section A. Chapter 103, RSMo, is amended by adding thereto one new section, to be known as section 103.185, to read as follows:

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

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

(1) "Allowed amount", the contractually agreed upon amount paid by a carrier to a health care provider participating in the carrier's network or the amount the health plan is required to pay under the health plan policy for out-of-network covered benefits provided to the patient;

(2) "Department", the department of insurance, financial institutions and professional registration;

(3) "Health care provider", as such term is defined in section 376.1350;

(4) "Health carrier" or "carrier", as such term is defined in section 376.1350;

(5) "Patient", any person employed full time by the state or a participating member agency or a person eligible for coverage by a state-sponsored retirement system or a retirement system sponsored by a participating member agency;

(6) "Program", the shared savings incentive program established by a carrier under this section;

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) "Shoppable health care service", a health care service for which a carrier offers a shared savings incentive payment under a program established by the carrier under this section. A shoppable heath care service includes, but is not limited to, health care services in the following categories:

(a) Physical and occupational therapy services;

(b) Obstetrical and gynecological services;

(c) Radiology and imaging services;

(d) Laboratory services;

(e) Infusion therapy;

(f) Inpatient and outpatient surgical procedures; and

(g) Outpatient nonsurgical diagnostic tests or procedures.

This list may be expanded by the department.

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

(2) 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, within two business days, disclose the amount that will be charged for the nonemergency admission, procedure, or service, including the amount for any facility fees required.

(3) If a health care provider is unable to quote a specific amount under subdivision (1) or (2) 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 his or her ability to obtain an updated estimate once additional information is determined.

(4) If a patient or prospective patient is covered by insurance, a health care provider that participates in a carrier's network shall, upon request of a patient or prospective patient, provide, based on the information available to the health care provider at the time of the request, sufficient information regarding the proposed nonemergency admission, procedure, or service for the patient or prospective patient to receive a cost

estimate from his or her insurance carrier to identify out-of-pocket costs, which could be through an applicable toll-free telephone number or website. A health care provider may assist a patient or prospective patient in using a carrier's toll-free number and website.

4. A carrier shall establish an interactive mechanism on its publicly accessible website that enables an enrollee to request and obtain from the carrier information on the payments made by the carrier to network providers for health care services. The interactive mechanism shall allow an enrollee seeking information about the cost of a particular health care service to compare costs among network providers as established in subdivision (3) of subsection 6 of this section.

5. (1) Within two business days of an enrollee's request, a carrier shall provide a good faith estimate of the amount the enrollee will be responsible to pay out-of-pocket for a proposed nonemergency procedure or service that is a medically necessary, covered benefit from a carrier's network provider, including any co-payment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit based on the information available to the carrier at the time the request is made.

(2) Nothing in this section shall prohibit a 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 carrier shall notify an enrollee that these 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.

6. A carrier shall develop and implement a program that provides incentives for enrollees in a health plan who elect to receive shoppable health care services that are covered by the plan from providers that charge less than the average price paid by such carrier for such shoppable health care services.

(1) Incentives may be calculated as a percentage of the difference in price, as a flat dollar amount, or by some other reasonable methodology approved by the department. The carrier shall provide the incentive as a cash payment to the enrollee.

(2) The incentive program shall provide enrollees with at least fifty percent of the carrier's saved costs for each service or category of shoppable health care service resulting from shopping by enrollees. A carrier shall not be required to provide a payment or credit to an enrollee if the carrier's saved cost is fifty dollars or less.

(3) A carrier shall base the average price on the average amount paid to an in-network provider for the procedure or service under the enrollee's health plan within

a reasonable time frame not to exceed one year. A carrier may determine an alternate methodology for calculating the average price if approved by the department.

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

8. Prior to offering the program to any enrollee, a carrier shall file a description of the program established by the carrier under this section with the department in the manner determined by the department. The department may review the filing made by the carrier to determine if the carrier's program complies with the requirements of this section. Filings and any supporting documentation made under this subsection are confidential until the filing has been reviewed or the waiver request has been granted or denied by the department.

9. If an enrollee elects to receive a shoppable health care service from an out-of-network provider that results in a shared savings incentive payment, a carrier shall apply the amount paid for the shoppable health care service toward the enrollee's member cost sharing as specified in the enrollee's health plan as if the health care service was provided by an in-network provider.

10. A shared savings incentive payment made by a carrier in accordance with this section is not an administrative expense of the carrier for rate development or rate filing purposes.

11. Annually, a carrier shall file with the department for the most recent calendar year the total number of shared savings incentive payments made under this section, the use of shoppable health care services by category of service for which shared savings incentives were made, 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 prices by service for such transactions, and the total number and percentage of a carrier's enrollees who participated in such transactions. Beginning April 1, 2019, and annually by April first of each year thereafter, the department shall submit an aggregate report for all carriers filing the information required by this subsection to the legislative committees of the house of representatives and the senate having jurisdiction over health insurance matters.

12. The department may adopt 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, 2017, shall be invalid and void.

Section B. The provisions of section 103.185 of section A of this act shall become effective on March 1, 2018.

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