SECOND REGULAR SESSION

HOUSE BILL NO. 2125

99TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE HELMS.

5866H.02I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to the right to shop act.

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 376.1600, to read as follows:

376.1600. 1. This section shall be known and may be cited as the "Right to Shop Act". As used in this section, the following terms mean:

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

(2) "Average", mean, median, or mode;

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

(4) "Health care provider", the same meaning as in section 376.1350;

(5) "Health carrier", the same meaning as in section 376.1350;

(6) "Program", the comparable health care service incentive program established by a carrier under this section.

2. (1) Beginning January 1, 2019, a carrier offering a health plan in this state shall develop and implement a program that provides incentives for enrollees in a health plan who elect to receive a comparable health care service that is covered by the plan from

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.

providers that charge less than the average allowed amount paid by that carrier to network providers for that comparable health care service.

(2) Incentives may be calculated as a percentage of the difference in allowed amounts to the average, 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 or credit toward the enrollee's annual in-network deductible and out-of-pocket limit. Carriers may allow enrollees to decide which method they prefer to receive the incentive.

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

(4) A carrier shall base the average amount on the average allowed amount paid to network providers 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 allowed amount if approved by the department. A carrier shall, at minimum, inform enrollees of their ability and the process to request the average allowed amount for a procedure or service, both on their website and in their benefit plan materials.

(5) Eligibility for an incentive payment may require an enrollee to demonstrate, through reasonable documentation such as a quote from the provider, that the enrollee shopped prior to receiving care from the provider who charges less for the comparable health care service than the average allowed amount paid by that carrier. Carriers shall provide additional mechanisms for the enrollee to satisfy this requirement by utilizing the carrier's cost transparency website or toll-free number, as established under this section.

3. A health 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, a description of the incentives available to an enrollee, and how to earn such incentives to any enrollee who is enrolled in a health plan eligible for the program.

4. A comparable health care service 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.

5. 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 approved or denied by the department.

6. Annually, a carrier shall file with the department for the most recent calendar year the total number of comparable health care service incentive payments made under this section, the use of comparable health care services by category of service for which comparable health care service incentives are 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 allowed amount by service for such transactions, and the total number and percentage of a carrier's enrollees who participated in such transactions. Beginning no later than eighteen months after implementation of comparable health care service incentive programs under this section, 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 having jurisdiction over health insurance matters. The department may set reasonable limits on the annual reporting requirements of carriers to focus on the more popular comparable health care services.

7. 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, 2018, shall be invalid and void.

8. Beginning upon approval of the next health insurance rate filing after the effective date of this section, a carrier offering a health plan in this state shall comply with the following requirements:

(1) 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 entities or 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 network providers, estimate out-of-pocket costs applicable to that enrollee's health plan, and the average amount paid to a network

provider for the procedure or service under the enrollee's health plan within a reasonable time frame 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 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. A carrier may contract with a third-party vendor to satisfy the requirements of this subdivision;

(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; and

(3) A 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 nonemergency procedure or service.

9. 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 in its provider network within a reasonable time frame, not to exceed one year, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's price and, upon request by 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 a network provider. The 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. A carrier may base the average paid to 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 the state. A carrier shall, at a minimum, inform enrollees of their ability and the process to request the average allowed amount paid for a procedure or service, both on their website but also in benefit plan materials.

10. (1) 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 within two working days, 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 their health 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.

(2) If a health care provider is unable to quote a specific amount under 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.

(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, within two working days, disclose 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 patient's ability, for those 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 in comparing out-of-pocket and contracted amounts paid for his or her care to different providers for similar services. This notification shall inform patients of their right to obtain services from different providers regardless of a referral or recommendation from the provider, and that seeing a high-value provider, either their currently referred provider or a different provider, may result in an incentive to the patient if he or she follows the steps set by his or her health carrier. The notification shall give an outline of the parameters of potential incentives approved in this section. It shall also notify the patient that his or her carrier is required to provide enrollees an estimate of out-of-pocket costs and contracted amounts paid for their care from 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 patients that informs them of carrier-specific price transparency tools or toll-free phone numbers.

11. The Missouri consolidated health care plan board shall conduct an analysis no later than one year from the effective date of this section 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

board shall communicate the rationale for its decision to relevant legislative committees in writing.

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