FIRST REGULAR SESSION

SENATE BILL NO. 245

99TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SATER.

Read 1st time January 4, 2017, and ordered printed.

ADRIANE D. CROUSE, Secretary.

1020S.02I

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to shared savings incentive programs, with an 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 or the amount the health plan is required to pay under the health plan policy or certificate of insurance for out-of-network covered benefits provided to the patient;

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

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

(4) "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;

(5) "Program", the shared savings incentive program established by a health carrier pursuant to this section;

(6) "Shoppable health care service", a health care service for which a health carrier offers a shared savings incentive payment under a program established by a health carrier pursuant to this section. A

shoppable health care service includes, at a minimum, 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 surgical procedures;

(g) Outpatient surgical procedures;

(h) Any other therapy, service, or procedure approved by the director.

3. (1) Prior to a non-emergency 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 disclose within two working days the allowed amount of the non-emergency admission, procedure, or service, including the amount for any facility fees required.

(2) Prior to a non-emergency 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 will be charged for the non-emergency 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 subdivisions (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 non-emergency 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.

(4) If a patient or prospective patient is covered by insurance, a health care provider that participated in the health 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 non-emergency 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.

4. A health carrier shall establish access to 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 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 in-network providers as established in subdivision (4) of subsection 6 of this section.

5. (1) Within two working days of an enrollee's request, a health carrier shall provide a good faith estimate of the allowed amount and the amount the enrollee will be responsible to pay out-of-pocket for a proposed non-emergency admission, 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.

(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 non-emergency admission, 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 will be responsible to pay may vary due to unforeseen services that arise out of the proposed non-emergency admission, procedure, or service.

6. (1) Unless a waiver has been granted as provided in subsection 8 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 shoppable health care services that are covered by the plan from providers that charge less than the average price paid by that carrier for that shoppable health care service.

(2) Incentives may be calculated as a percentage of the difference in price, 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.

(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 shoppable 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 fifty dollars or less.

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

7. 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.

8. Prior to offering the program to any enrollee, a health carrier shall file 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 reviewed or the waiver request has been granted or denied by the director.

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 health 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 services were provided by an in-network provider.

10. A shared savings 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.

11. A health carrier shall annually file with the director, for the most recent calendar year, the total number of shared savings incentive payments made pursuant to this section, the use of shoppable health care services by category of service for which shared savings 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 prices 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, 2018, 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.

12. The director of the department of insurance, financial institutions and professional registration shall 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 the effective date of this section shall be invalid and void.

Section B. Section A of this act shall become effective February 28, 2018.

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