

SECOND REGULAR SESSION

SENATE BILL NO. 744

99TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SATER.

Pre-filed December 1, 2017, and ordered printed.

ADRIANE D. CROUSE, Secretary.

4944S.01I

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to comparable health care service 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
2 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
2 **"Missouri Right to Shop Act".**

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

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

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

8 **(3) "Director", the director of the department of insurance,**
9 **financial institutions and professional registration;**

10 **(4) "Health care provider" or "provider", as defined in section**
11 **376.1350;**

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

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

19 **(7) "Comparable health care service", any covered non-emergency**
20 **health care service or bundle of services. The director may limit what**
21 **is considered a comparable health care service if a carrier can**

22 demonstrate allowed amount variation among in-network providers is
23 less than fifty dollars.

24 3. (1) Unless a waiver has been granted as provided in
25 subsection 6 of this section, a health carrier shall develop and
26 implement a program that provides incentives for enrollees in a health
27 plan who elect to receive comparable health care services that are
28 covered by the plan from providers that charge less than the average
29 allowed amount paid by that carrier to in-network providers for those
30 comparable health care services.

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

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

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

54 (5) Eligibility for an incentive payment may require an enrollee
55 to demonstrate, through reasonable documentation such as a quote
56 from the provider, that the enrollee shopped prior to receiving care
57 from the provider who charges less for the comparable health care
58 service than the average allowed amount paid by that health

59 carrier. Health carriers shall provide additional mechanisms for the
60 enrollee to satisfy this requirement by utilizing the carrier's cost
61 transparency website or toll-free number established under this
62 section.

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

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

72 6. Prior to offering the program to any enrollee, a health carrier
73 shall file with the director a description of the program established by
74 the health carrier pursuant to this section or a request for waiver of
75 the requirements of this section in a manner prescribed by the
76 director. The director may review the filing made by the health carrier
77 to determine whether the health carrier's program complies with the
78 requirements of this section. Filings made pursuant to this subsection,
79 including any supporting documentation, are confidential until the
80 filing has been granted or denied by the director.

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

96 on the comparable health care services for which incentive payments
97 are most frequently paid.

98 8. (1) A health carrier shall establish an interactive mechanism
99 on its publicly accessible website that enables an enrollee to request
100 and obtain from the health carrier, or a designated third-party,
101 information on the payments made by the health carrier to in-network
102 entities and providers for comparable health care services, as well as
103 quality data for those providers, to the extent available. The
104 interactive mechanism shall allow an enrollee seeking information
105 about the cost of a particular health care service to compare allowed
106 amounts among in-network providers, estimate out-of-pocket costs
107 applicable to that enrollee's health plan, and the average paid to a
108 network provider for the procedure or service under the enrollee's
109 health plan within a reasonable timeframe not to exceed one year. The
110 out-of-pocket estimate shall provide a good faith estimate of the amount
111 the enrollee will be responsible to pay out-of-pocket for a proposed non-
112 emergency procedure or service that is a medically necessary covered
113 benefit from a health carrier's in-network provider, including any
114 copayment, deductible, coinsurance, or other out-of-pocket amount for
115 any covered benefit, based on the information available to the health
116 carrier at the time the request is made. A health carrier may contract
117 with a third-party vendor to satisfy the requirements of this
118 subdivision.

119 (2) Nothing in this section shall prohibit a health carrier from
120 imposing cost-sharing requirements disclosed in the enrollee's
121 certificate of coverage for unforeseen health care services that arise
122 out of the non-emergency procedure or service or for a procedure or
123 service provided to an enrollee that was not included in the original
124 estimate.

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

129 9. (1) If an enrollee elects to receive a covered health care
130 service from an out-of-network provider at a price that is the same or
131 less than the average that an enrollee's health carrier pays for that
132 service to health care providers within its provider network within a

133 reasonable timeframe not to exceed one year, the health carrier shall
134 allow the enrollee to obtain the service from the out-of-network
135 provider at the provider's price, and upon request of the enrollee shall
136 apply the payments made by the enrollee for that health care service
137 toward the enrollee's deductible and out-of-pocket maximum as
138 specified in the enrollee's health plan as if the health care services had
139 been provided by an in-network provider. The health carrier shall
140 provide a downloadable or interactive online form to the enrollee for
141 the purpose of submitting proof of payment to an out-of-network
142 provider for purposes of administering this section.

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

150 10. (1) If a patient or prospective patient is covered by
151 insurance, a health care provider within the health carrier's network
152 shall, upon request of a patient or prospective patient, provide within
153 two working days, based on the information available to the health care
154 provider at the time of the request, sufficient information regarding the
155 proposed non-emergency admission, procedure, or service for the
156 patient or prospective patient to receive a cost estimate from their
157 health carrier to identify out-of-pocket costs which could be through an
158 applicable toll-free number, website, or access to a third-party service
159 that meets the requirements of this section. A health care provider
160 may assist a patient or prospective patient in using a carrier's toll-free
161 number, website, or third-party service.

162 (2) If a health care provider is unable to quote a specific amount
163 under subdivision (1) of this subsection in advance due to the health
164 care provider's inability to predict the specific treatment or diagnostic
165 code, the health care provider shall disclose what is known for the
166 estimated amount for a proposed non-emergency admission, procedure,
167 or service, including the amount for any facility fees required. A health
168 care provider shall disclose the incomplete nature of the estimate and
169 inform the patient or prospective patient of their ability to obtain an

170 updated estimate once additional information is determined.

171 (3) Prior to a non-emergency admission, procedure, or service,
172 and upon request by a patient or prospective patient, a health care
173 provider outside the patient's or prospective patient's insurer network
174 shall disclose within two working days the amount that will be charged
175 for the non-emergency admission, procedure, or service, including the
176 amount for any facility fees required.

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

199 11. The director of the department of insurance, financial
200 institutions, and professional registration may promulgate rules as
201 necessary to implement the provisions of this section. Any rule or
202 portion of a rule, as that term is defined in section 536.010 that is
203 created under the authority delegated in this section shall become
204 effective only if it complies with and is subject to all of the provisions
205 of chapter 536, and, if applicable, section 536.028. This section and
206 chapter 536 are nonseverable and if any of the powers vested with the

207 general assembly pursuant to chapter 536, to review, to delay the
208 effective date, or to disapprove and annul a rule are subsequently held
209 unconstitutional, then the grant of rulemaking authority and any rule
210 proposed or adopted after August 28, 2018, shall be invalid and void.

211 12. The board of trustees of the Missouri consolidated health
212 care plan shall conduct an analysis no later than January 1, 2020, of the
213 cost effectiveness of implementing an incentive-based program for
214 current enrollees and retirees. Any program found to be cost effective
215 shall be implemented as part of the next open enrollment. The Missouri
216 consolidated health care plan shall communicate the rationale for its
217 decision to relevant legislative committees in writing.

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

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