Sen. Jim Oberweis

Filed: 4/11/2018

AMENDMENT TO SENATE BILL 2807

AMENDMENT NO. _____. Amend Senate Bill 2807 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Right to Shop Act.

Section 5. Applicability. This Act applies to health benefit plans amended, delivered, issued, or renewed in this State on or after January 1, 2019.

Section 10. Definitions. In this Act:

"Allowed amount" means the contractually agreed upon amount paid by a carrier to a provider participating in the carrier's network.

"Carrier" means an entity that provides a health benefit plan in this State and is subject to State insurance regulation.

"Comparable health care service" means a covered non-emergency health care service or bundle of services. The Director may limit what is considered a comparable health care service if a carrier demonstrates that the allowed amount variation among network providers is less than $50.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Enrollee" means an individual enrolled in a health benefit plan.

"Health benefit plan" or "health plan" means a policy, contract, certificate, plan, or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" or "health plan" does not include individual, accident-only, credit, dental, vision, Medicare supplement, hospital indemnity, long term care, specific disease, stop-loss or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Network" means the group or groups of preferred providers providing services to a network plan.

"Network plan" means an individual or group policy of health plans that either requires a covered person to use or

creates incentives, including financial incentives, for an enrollee to use providers managed, owned, under contract with, or employed by the carrier.

"Program" means the comparable health care service incentive program established by a carrier pursuant to this Act.

"Provider" means a physician, hospital facility, or other health care practitioner licensed or otherwise authorized to furnish health care services consistent with State law.

Section 15. Health care service incentive program.

(a) Beginning January 1, 2019, a carrier offering a health benefit 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 health plan from a provider that collects less than the average in-network allowed amount paid by that carrier to a network provider for that comparable health care service.

(b) 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, gift cards, or credits toward the enrollee's annual in-network deductible and out-of-pocket limit or premium reductions.

(c) A carrier shall make the health care service incentive

program available as a component of all health plans offered in the individual and small group markets by the carrier in this State, but not including plans in which enrollees receive a premium subsidy under the federal Patient Protection and Affordable Care Act. 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 an enrollee who is enrolled in a health plan eligible for the program. A carrier may contract with a third-party vendor to satisfy the requirements of this subsection.

Section 20. Administrative expense; filing requirements.

(a) A comparable health care service incentive payment made by a carrier in accordance with this Act is not an administrative expense of the carrier for rate development or rate filing purposes.

(b) Prior to offering the health care service incentive program to an enrollee, a carrier shall file a description of the program with the Department in the manner determined by the Department. The Director may review the filing made by the carrier to determine whether the carrier's program complies with the requirements of this Act. Filings and any supporting documentation are confidential until the filing has been approved or denied by the Department.

Section 25. Health care price transparency tools.

(a) Beginning upon approval of the next health insurance rate filing after the effective date of this Act, 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 providers for comparable health care services, as well as quality data for those providers, to the extent available. The interactive mechanism must allow an enrollee seeking information about the cost of a particular health care service to:

(A) compare allowed amounts among network providers;

(B) estimate out-of-pocket costs applicable to that enrollee's health plan; and

(C) provide the average paid within a reasonable timeframe (not to exceed one year) to network providers for the procedure or service under the enrollee's health plan.

The out-of-pocket estimate must provide a good faith estimate of the amount the enrollee will be responsible to pay out-of-pocket for a proposed non-emergency procedure or service that is a medically necessary covered benefit

from a carrier's network provider, including a copayment, deductible, coinsurance, or other out-of-pocket amount for a 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 paragraph.

(2) A carrier shall notify an enrollee that the information provided under paragraph (1) is an estimation of 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 procedure or service.

(b) Nothing in this Section prohibits 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 non-emergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

Section 30. Patient freedom and choice; lower prices.

(a) 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 carrier pays for that service to providers in its provider network within a reasonable timeframe, 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.

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

Section 35. State group health benefits plan; analysis. The Director of Central Management Services shall conduct an analysis no later than one year from the effective date of this Act of the cost effectiveness of implementing an incentive-based program for enrollees and retirees of the State group health benefits plan offered under the State Employees Group Insurance Act of 1971. A program found to be cost effective shall be implemented as part of the next open enrollment. The Director of Central Management Services shall

communicate the rationale for the decision to relevant General Assembly committees in writing.

Section 40. Rulemaking authority. The Director may adopt reasonable rules as necessary to implement the purposes and provisions of this Act.

Section 99. Effective date. This Act takes effect upon becoming law.".