WEST VIRGINIA LEGISLATURE

2018 REGULAR SESSION

Introduced

House Bill 4021

BY DELEGATES HOUSEHOLDER, SUMMERS, BUTLER AND

DEAN

[Introduced January 11, 2018; Referred

to the Committee on Banking and Insurance then the

Judiciary]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §16-53-1, §16-53-2, §16-53-3, §16-53-4, §16-53-5, and §16-53-6 all relating to creating a process which permits a person to search for highest value health care; designating article as "Right to Shop"; providing definitions; establishing a Comparable Health Care Service Incentive Program, beginning January 1, 2019; requiring insurance carriers to develop health care transparency tools; patient freedom and choice to seek health care insurance; requiring price transparency; and requiring the Public Employees Insurance Agency to conduct an analysis of the cost effectiveness of implementing an incentive-based program for current enrollees and retirees.

Be it enacted by the Legislature of West Virginia:

ARTICLE 53. RIGHT TO SHOP.

§16-53-1. Definitions.

The following terms are defined:

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

"Average" means mean, median or mode.

"Comparable health care service" means any covered nonemergency health care service or bundle of services. The Insurance Commissioner may limit what is considered a comparable health care service if a carrier can demonstrate allowed amount variation among network providers is less than $50.

"Health Care Entity" has the same meaning as "Health Care Provider" as defined in §16-1C-1 of this code.

"Insurance carrier" means all health insurance companies regulated and licensed in state and the Public Employees Insurance Agency.

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

§16-53-2. Establishment of a Comparable Health Care Service Incentive Program.

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

(1) 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 Insurance Commissioner. 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 let enrollees decide which method they prefer to receive the incentive.

(2) The incentive program must 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 when the carrier's saved cost is $25 or less.

(3) A carrier will base the average amount on the average allowed amount paid to a network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed one year. A carrier may determine an alternate methodology for calculating the average allowed amount if approved by the Insurance Commissioner. 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 but also in benefit plan material.

(4) Eligibility for an incentive payment may require an enrollee 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, established under this article.

(b) An insurance 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.

(c) 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.

(d) Prior to offering the program to any enrollee, a carrier shall file a description of the program established by the carrier pursuant to this section with the Insurance Commissioner. The Insurance Commissioner 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 pursuant to this section are confidential until the filing has been approved or denied by the Insurance Commissioner.

(e) Annually a carrier shall file with the Insurance Commissioner for the most recent calendar year the total number of comparable health care service incentive payments made pursuant to 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 that 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 1st of each year thereafter, the Insurance Commissioner shall submit an aggregate report for all carriers filing the information required by this subsection to the legislative committee having jurisdiction over health insurance

matters. The Insurance Commissioner may set reasonable limits on the annual reporting requirements on carriers to focus on the more popular comparable health care services.

(f) The Insurance Commissioner may propose legislative rules in accordance with the provisions of §29A-3-1 *et seq.* of this code to implement this section.

§16-53-2. Health Care Price Transparency Tools.

Beginning upon approval of the next health insurance rate filing after enactment, 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 must 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 enrollees health plan, and the average paid to a network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed one year. 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 nonemergency procedure or service that is a medically necessary covered benefit from a carrier's network provider, including any copayment, 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.

(2) Nothing in this section may 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.

§16-53-4. Patient Freedom and Choice.

(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 insurance carrier pays for that service to health care providers in its provider network within a reasonable time frame, not to exceed one year, or the statewide average for the same covered health care service based on data reported on a publicly accessible health care cost website of the West Virginia Health Care Authority Database, 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 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 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 material.

§16-53-5. Price Transparency.

(a) If a patient or prospective patient is covered by insurance, a health care entity that participates in a carrier's network shall provide a patient or prospective patient, within two working days, based on the information available to the health care entity at the time, sufficient information regarding the proposed nonemergency admission, procedure or service for the patient or prospective patient to receive a cost estimate from their insurance carrier to identify out-of-pocket

costs which could be through an applicable toll-free telephone number or website. A health care entity may assist a patient or prospective patient in using a carrier's toll-free number and website.

(b)If a health care entity is unable to quote a specific amount in advance due to the health care entity's inability to predict the specific treatment or diagnostic code, the health care entity 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 entity 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.

(c) Prior to a nonemergency admission, procedure or service and upon request by a patient or prospective patient, a health care entity outside the patient's or prospective patient's insurer network shall, within two working days, disclose the price that will be charged for the nonemergency admission, procedure or service, including the amount for any facility fees required.

§16-53-6. Public Employees Insurance Agency Analysis.

The Public Employees Insurance Agency shall conduct an analysis no later than one year from the date of enactment of this article 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 Public Employees Insurance Agency shall communicate the rationale for its decision to the Legislative Oversight Commission of Health and Human Resources Accountability.

NOTE: The purpose of this bill is to. permit an individual to shop for the highest value care to receive health care which may make that individual eligible for a monetary incentive. The bill creates a new article designated as "Right to Shop" and provides definitions, establishes a Comparable Health Care Service Incentive Program, beginning January 1, 2019; requires insurance carriers to develop health care transparency tools; permits patient freedom and choice to seek health care insurance; requires price transparency; and requires the Public Employees Insurance Agency to conduct an analysis of the cost effectiveness of implementing an incentive-based program for current enrollees and retirees.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.