SB116

173256-1

By Senator Ward

RFD: Banking and Insurance

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SYNOPSIS: This bill would establish the Alabama Right to Shop Act.

This bill would require a health care provider to provide, upon a patient's request, an estimate of the allowed amount or charge for health care services if the health care provider is in the patient's health benefit plan network or amount or charge if the health care provider is out-of-network and to assist a patient in obtaining information about the patient's out-of-pocket costs.

This bill would require a health benefit plan to establish a toll-free number and website to provide information to enrollees about health care costs and to provide a binding estimate for the maximum allowed amount or charge for in-network and out-of-network services for a proposed admission, procedure, or service and the estimated amount the enrollee will be responsible to pay for a proposed

admission, procedure, or service that is a medically necessary covered benefit.

The bill would also require a health benefit plan in certain circumstances to pay to an enrollee certain saved costs if an enrollee elects to receive health care services from an out-of-network provider where the out-of-network services cost less than in-network services.

A BILL

TO BE ENTITLED

AN ACT

Relating to health insurance; to require a health care provider to provide, upon a patient's request, an estimate of the allowed amount or charge for health care services if the health care provider is in the patient's health benefit plan network or amount or charge if the health care provider is out-of-network and to assist a patient in obtaining information about the patient's out-of-pocket costs; to require a health benefit plan to establish a toll-free number and website to provide information to enrollees about health care costs and to provide a binding estimate for the maximum allowed amount or charge for in-network and out-of-network services for a proposed admission, procedure, or service and the estimated amount the enrollee will be responsible to pay for a proposed admission, procedure, or

service that is a medically necessary covered benefit; and to require a health benefit plan in certain circumstances to pay to an enrollee certain saved costs if an enrollee elects to receive health care services from an out-of-network provider where the out-of-network services cost less than in-network services.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. This act shall be known and may be cited as the Alabama Right to Shop Act.

Section 2. As used in this act, the following words shall have the following meanings:

(1) ALLOWED AMOUNT. The contractually agreed upon amount paid by a health benefit plan to a health care provider participating in the health benefit plan's network or the amount the health benefit plan is required to pay under the health benefit plan's policy for out-of-network covered benefits provided to the patient.

(2) HEALTH BENEFIT PLAN. An individual or group insurance policy or plan that covers hospital, medical, or surgical expenses, a health maintenance organization, a preferred provider organization, a medical service organization, a physician-hospital organization, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes health care services to patients, insureds, or beneficiaries in this state. For the purposes of this chapter, a health benefit plan located or domiciled outside of the State of Alabama is deemed

to be subject to this chapter if it receives, processes, adjudicates, pays, or denies claims for health care services submitted by or on behalf of patients, insureds, or beneficiaries who reside in the State of Alabama or who receive health care services in the State of Alabama. The term includes, but is not limited to, entities created pursuant to Article 6, Chapter 20, Title 10A, Code of Alabama 1975.

(3) HEALTH CARE PROVIDER. An individual or entity that for compensation or in anticipation of receiving compensation provides or arranges for the provision of health care services in the state.

Section 3. (a) Prior to an admission, procedure, or service and upon request by a patient or prospective patient, a health care provider, within two working days, shall disclose either of the following:

(1) The allowed amount of the admission, procedure, or service, including any facility fees required, if the health care provider is in the patient's health benefit plan network; or

(2) The amount that will be charged for the admission, procedure, or service, including any facility fees required, if the health care provider is outside the patient's health benefit plan network.

(b) If a health care provider is unable to quote a specific amount in advance due to the health care provider's inability to predict the specific treatment or diagnostic code, the health care provider shall do all of the following:

(1) Disclose the incomplete nature of the estimate.

(2) Inform the patient or prospective patient of the health care provider's ability to obtain an updated estimate once additional information is obtained.

(3) Disclose what is known concerning:

a. The estimated allowed amount for a proposed admission, procedure, or service, including any facility fees required, if the health care provider is in the patient's health benefit plan network; or

b. The estimated amount that will be charged for a proposed admission, procedure, or service, including any facility fees required, if the health care provider is outside the patient's health benefit plan network.

(c) Upon request of a patient or prospective patient, a health care provider that participates in the patient's or prospective patient's health benefit plan network shall provide sufficient information regarding the proposed admission, procedure, or service, based on the information available to the health care provider at the time of the request, for the patient or prospective patient to use that health benefit plan's applicable toll-free telephone number and website to disclose out-of-pocket costs according to Section 4.

(d) A health care provider may assist a patient or prospective patient in using a health benefit plan's toll-free number and website.

Section 4. A health benefit plan shall comply with all of the following requirements with respect to the costs of health care services:

(1) A health benefit plan shall establish a toll-free telephone number and website that enables an enrollee to request and obtain from the health benefit plan information on the average price paid in the past 12 months to in-network health care providers for a proposed admission, procedure, or service in each county and to request an estimate pursuant to subdivision (2).

(2) Within two business days of an enrollee's request, a health benefit plan shall provide a binding estimate for the maximum allowed amount or charge for a proposed admission, procedure, or service and the estimated amount the enrollee will be responsible to pay for a proposed admission, procedure, or service that is a medically necessary covered benefit, based on the information available to the health benefit plan at the time the request is made, including any facility fee, copayment, deductible, coinsurance, or other out-of-pocket amount for any covered health care benefits.

(3) Subject to procedures and services provided meeting the health benefit plan's requirements to be covered, an enrollee may not be required to pay more than the disclosed allowed amounts for the covered health care benefits that were quoted in the binding estimate. Nothing in this section shall prohibit a health benefit plan from imposing cost-sharing requirements disclosed in the enrollee's certificate of

coverage for health care services that arise out of the proposed admission, procedure, or service or the procedures or services provided that were not in the original binding estimate.

(4) A health benefit plan shall notify an enrollee that the provided estimates are estimated costs and that the actual amounts the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure, or service or the procedures or services not meeting the health benefit plan's conditions to be considered a covered benefit.

(5) If an enrollee elects to receive health care services from a provider that cost less than the average amount paid in his or her county of residence for a particular admission, procedure, or service, a health benefit plan shall pay to an enrollee 50 percent of the saved cost, up to a maximum of seven thousand five hundred dollars ($7,500) in each plan year. A health benefit plan is not required to make a payment if the saved cost is fifty dollars ($50) or less. Payments required under this section shall be made within 30 days of the date the service is billed by the provider.

(6) If an enrollee elects to receive covered health care services from an out-of-network provider that cost less than the average amount of all in-network providers over the past 12 months for a particular admission, procedure, or service, a health benefit plan shall apply the enrollee's share of the cost of those health care services as specified

in the enrollee's health benefit plan toward the enrollee's cost sharing as if the health care services were provided by an in-network provider.

(7) By February 1 of each year, a health benefit plan shall file all of the following with the Commissioner of Insurance for the most recent calendar year:

a. The total number of requests for a binding estimate made pursuant to subdivision (2).

b. The total number of transactions made pursuant to subdivision (5).

c. The average cost by service for transactions made pursuant to subdivision (5).

d. The total savings achieved below the average cost by service for transactions made pursuant to subdivision (5).

e. The total payments made to enrollees' transactions made pursuant to subdivision (5).

f. The total number and percentage of a health benefit plan's enrollees that participated in transactions made pursuant to subdivision (5).

Section 5. This act shall become effective on the first day of the third month following its passage and approval by the Governor, or its otherwise becoming law.