PROPOSED AMENDMENT TO LD 1305,
AN ACT TO ENCOURAGE HEALTH INSURANCE CONSUMERS
TO COMPARISON SHOP FOR HEALTH CARE PROCEDURES AND TREATMENTS

[changes from original bill shown by strikethrough and in bold italics]

Amend the bill by striking out the title and inserting in its place the following:

An Act to Improve Price Transparency, Help Maine Consumers Comparison Shop for Certain Health Care Procedures and Lower Health Care Costs

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

Sec. 1. 22 MRSA §1718-B, sub-§1, ¶C is enacted to read:

C. "Allowed amount" means***, with respect to health care services provided to a patient covered by insurance,*** the contractually agreed upon amount paid by a carrier to a health care entity ***participating in a carrier's provider network*** ~~for health care services provided to a patient covered by insurance~~ ***or the amount a carrier is required to pay to an out-of network health care entity under a health plan policy, contract or certificate before the application of any cost-sharing required to be paid by a patient under a health plan policy, contract or certificate*** ~~for health care services provided to a patient covered by insurance.~~

Sec. 2. 22 MRSA §1718-B, sub-§2 is amended to read:

2. **Requirements.** The following requirements apply to health care entities.

A. A health care entity shall have available to patients the prices of the health care entity's most frequently provided health care services and procedures. The prices stated must be the prices that the health care entity charges patients directly when there is no insurance coverage for the services or procedures or when reimbursement by an insurance company is denied. The prices stated must be accompanied by descriptions of the services and procedures and the applicable standard medical codes or current procedural technology codes used by the American Medical Association.

B. A health care entity shall inform patients about the availability of prices for the most frequently provided health care services and procedures.

C. A health care entity shall prominently display in a location that is readily accessible to patients information on the price transparency tools available from the publicly accessible website of the Maine Health Data Organization established pursuant to chapter 1683 to assist consumers with obtaining estimates of costs associated with health care services and procedures ***and information on the patient's right to obtain estimates of costs pursuant to subsection 3 and the patient's right to shop for services and receive payment for shared savings pursuant to Title 24-A, section 4303, subsection 20 if the patient is covered by a health plan***.

A health care entity that does not routinely render services directly to patients in an office setting may satisfy this subsection by providing the information on its publicly accessible website.

Sec. *3* ~~2~~. 22 MRSA §1718-B, sub-§§3 and 4 are enacted to read:

3. Estimate of charges prior to an admission, procedure or service. Prior to ~~an~~ ***a non-emergency*** admission, procedure or service and upon request by a patient or prospective patient, a health care entity shall, within 2 working days, disclose the allowed amount if the entity participates in the patient's carrier network or the amount that will be charged if the entity does not participate in the patient's carrier network for the admission, procedure or service, including the amount for any facility fees required. ***A health care entity shall also disclose that health care services or procedure may be provided to a patient by a practitioner that is not employed by the health care entity and may not participate in the provider network of the patient's health insurance carrier.*** 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 allowed amount if the entity participates in the patient's carrier network, or the amount that will be charged if the entity does not participate in the patient's carrier network for the proposed admission, procedure or service, including the amount for any facility fees required. The health care entity shall disclose the incomplete nature of the estimate and inform the patient or prospective patient of the ability to obtain an updated estimate once additional information is obtained. ~~If a health care entity fails to provide an estimate as required by this subsection, the health care entity may not bill the patient or the patient's insurance carrier for the admission, procedure or service.~~ ***If a health care entity fails to provide an estimate as required by this subsection, the health care entity may not bill the patient or the patient's insurance carrier more than the county average cost paid for the admission, procedure or service.*** Upon request of a patient or prospective patient who is covered by insurance, a health care entity that participates in a carrier's network shall, based on the information available to the health care entity at the time of the request, provide sufficient information regarding the proposed admission, procedure or service for the patient or prospective patient to use that carrier's applicable toll-free telephone number and publicly accessible website to obtain information about the amount of out-of-pocket costs in accordance with Title 24-A, section 4303, subsection 20. A health care entity may assist a patient or prospective patient in using a carrier's toll-free telephone number and publicly accessible website.

~~**4. Access to data.** Notwithstanding any other provision of law, a health care entity or another person designated by a health care entity or a patient or prospective patient shall have access at no cost to the all-payor and all-settings health care database based on claims established by the Maine Health Data Processing Center in accordance with section 682 for the purposes of providing information to a patient or prospective patient as required by subsection 3. Disclosure of data to a health care entity or another person pursuant to this subsection must be reasonably limited to the minimum extent necessary and any information disclosed must be used solely for the purposes of providing information to a patient or prospective patient as required by subsection 3.~~

Sec. *4* ~~3~~. 22 MRSA § 8712, sub-§ 2 is amended to read:

2. **Payments.** The organization shall create a publicly accessible interactive website that presents reports related to payments for services rendered by health care facilities and practitioners to residents of the State***, including health care facilities and practitioners located outside of the State***. The services presented must include, but not be limited to, imaging, preventative health, radiology and surgical services and other services that are predominantly elective ***and shoppable*** and may be provided to a large number of patients who do not have health insurance or are underinsured. The website must also be constructed to display prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors. Beginning ***January 1, 2016*** ~~October 1, 2012~~, price information posted on the website must be posted ***quarterly*** ~~semiannually~~, must display the date of posting and, when posted, must be current to within 12 months of the date of submission of the information. ***Beginning January 1, 2016, the publicly accessible website must report average payments by procedure by county. The website must include a function that allows an***

individual shopping for health care services as described in Title 24-A, section 4303, subsection 20 to print a confirmation report that will validate the individual's use of the website for the shared savings program.

Sec. *5* 4. 22 MRSA § 8712, sub-§§ 5 and 6 are enacted to read:

5. Review of data. The organization shall forward the payment information that will be posted on its publicly accessible website to the relevant carrier at least 30 days prior to the release of the data on the website. In the event there is a discrepancy with what the organization has calculated for payments and what the affected carrier has calculated for payments the organization will work with the affected carrier to resolve the issue and, if needed, may suppress the data in question until the issues are resolved.

6. Confirmation reports. The organization shall provide an annual report of the total number of confirmations generated by each carrier. Beginning February 1, 2017, the organization shall produce and distribute these reports to each carrier by February 1st of each year for the previous calendar year.

Sec. 6. 24-A MRSA § 4302, sub-§ 1 is amended to read:

1. **Description of plan.** A carrier shall provide to prospective enrollees and participating providers, and to members of the public and nonparticipating providers upon request, information on the terms and conditions of the plan to enable those persons to make informed decisions regarding their choice of plan. A carrier shall provide this information annually to current enrollees, participating providers and the superintendent. This information must be presented in a standardized format acceptable to the superintendent. In adopting rules or developing standardized reporting formats, the superintendent shall consider the nature of the health plan and the extent to which rules or standardized formats are appropriate to the plan. All written and oral descriptions of the health plan must be truthful and must use appropriate and objective terms that are easy to understand. These descriptions must be consistent with standards developed for supplemental insurance coverage under the United States Social Security Act, Title XVIII, 42 United States Code, Sections 301 to 1397 (1988). Descriptions of plans under this subsection must be standardized so that enrollees may compare the attributes of the plans. After a carrier has provided the required information, the annual information requirement under this subsection may be satisfied by the provision of any amendments to the materials on an annual basis. Specific items that must be included in a description are as follows:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not limited to the following types of exclusions and limitations:

(1) Health care services excluded from coverage;

(2) Health care services requiring copayments or deductibles paid by enrollees;

(3) Restrictions on access to a particular provider type;

(4) Health care services that are or may be provided only by referral; and

(5) Childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics;

B. Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may result in the enrollee being denied coverage or not being provided a particular service;

C. A general description of the methods used to compensate providers, including capitation and methods in which providers receive compensation based upon referrals, utilization or cost criteria;

D. An explanation of how health plan limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or other noncovered or out-of-plan services and limits on preexisting conditions and waiting periods;

E. The terms under which the health plan may be renewed by the plan members or enrollees, including any reservation by the health plan of any right to increase premiums;

F. A statement as to when benefits cease in the event of nonpayment of the prepaid or periodic premium and the effect of nonpayment upon the enrollees who are hospitalized or undergoing treatment for an ongoing condition;

G. A description of the manner in which the plan addresses the following: the provision of appropriate and accessible care in a timely fashion; an effective and timely grievance process and the circumstances in which an enrollee may obtain a 2nd opinion; timely determinations of coverage issues; confidentiality of medical records; and written copies of coverage decisions that are not explicit in the health plan agreement. The description must also include a statement explaining the circumstances under which health status may be considered in making coverage decisions in accordance with state and federal laws and that enrollees may refuse particular treatments without jeopardizing future treatment;

H. Procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or plan formulary, if any; a description of the formulary; and a description of the extent to which an enrollee will be reimbursed for the cost of a drug that is not on a plan list or plan formulary. Enrollees may request additional information related to specific drugs that are not on the drug formulary;

I. Information on where and in what manner health care services may be obtained;

J. A description of the independent external review procedures and the circumstances under which an enrollee is entitled to independent external review as required by this chapter;

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended; ~~and~~

L. A description of a provider profiling program that may be a part of the health plan, including the location of provider performance ratings in the plan materials or on a publicly accessible website, information explaining the provider rating system and the basis upon which provider performance is measured, the limitations of the data used to measure provider performance, the process for selecting providers and a conspicuous written disclaimer explaining the provider performance ratings should only be used as a guide for choosing a provider and that enrollees should consult their current provider before making a decision about their health care based on a provider rating~~.~~ ***and***

M. A description of the enrollee's right to to shop for services and receive payment for shared savings pursuant to section 4303, subsection 20.

Sec. *7* ~~3~~. 24-A MRSA §4303, sub-§20 is enacted to read:

20. Costs of health care services; estimates and payment. A carrier offering a health plan in this State shall comply with the following requirements with respect to the costs of health care services.

A. A carrier shall establish a toll-free telephone number and publicly accessible website that enables an enrollee to request and obtain from the carrier information on the average price paid in the past 12 months to network health care providers for a proposed admission, procedure or service in each ***county*** ~~geographic rating area established by the carrier~~ and to request an estimate pursuant to paragraph B.

B. Within 2 business days of an enrollee's request, a carrier shall provide a binding estimate for the maximum allowed amount or charge for a proposed ***non-emergency*** admission, procedure or service and the estimated amount the enrollee will be responsible to pay for a proposed ***non-emergency*** admission, procedure or service that is a medically necessary covered benefit, based on the information available to the carrier 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. ***Subject to meeting a carrier's requirements for services or procedures to be covered, an*** ~~An~~ enrollee may not be required to pay more than the disclosed amounts for the covered ***in-network*** health care benefits that were actually provided, except that this paragraph does not 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 proposed ***non-emergency*** admission, procedure or service ***or for a procedure or service provided to an enrollee that was not included in the original estimate***. 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 admission, procedure or service. For purposes of this paragraph, "allowed amount" means the contractually agreed upon amount paid by a carrier to a health care entity for health care services provided to an enrollee in a carrier's ***network or the allowed amount for out-of-network health care services provided to an enrollee in accordance with a carrier's*** health plan.

C. If an enrollee elects to receive ***shoppable*** health care services from a provider that cost less than the average amount for a particular admission, procedure or service, a carrier shall pay to an enrollee 50% of the saved cost to a maximum of $7,500 except that a carrier is not required to make a payment if the saved cost is $50 or less. ***The average amount is the average described in paragraph A and the shared savings is the difference between the average and the amount paid. A carrier may use the confirmation report produced by the Maine Health Data Organization pursuant to section 8712, subsection 6 to determine that an enrollee shopped for health care services and to calculate the shared savings.*** A payment to an enrollee must be made within 30 days. If an enrollee elects to receive health care services from an out-of-network provider that cost less than the average amount for a particular admission, procedure or service, a carrier shall apply the enrollee's share of the cost of those health care services as specified in the enrollee's health plan toward the enrollee's member cost sharing as if the health care services were provided by a network provider. ***A shared savings payment made by a carrier in accordance with this paragraph is not an administrative expense of the carrier for rate development or rate filing purposes. For the purposes of this paragraph, "shoppable health care services" means high volume, non-urgent health care services or procedures that an enrollee plans for and schedules in advance. The superintendent may amend the definition or define a list of shoppable health care services through rule. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.***

~~D. Notwithstanding any other provision of law, a carrier or another person designated by a carrier or an enrollee shall have access at no cost to the all-payor and all-settings health care database based on claims established by the Maine Health Data Processing Center in accordance with Title 22,~~

~~section 682 for the purposes of providing information to an enrollee as required by this subsection. Disclosure of data to a carrier or another person pursuant to this paragraph must be reasonably limited to the minimum extent necessary and any information disclosed must be used solely for the purposes of providing information to an enrollee as required by this subsection.~~

E. By ~~February~~ ***March*** 1st of each year, a carrier shall file with the superintendent for the most recent calendar year the total number of requests for a binding estimate pursuant to paragraph B, the total number of transactions made pursuant to paragraph C, the average cost by service for such transactions, the total savings achieved below the average cost by service for such transactions, the total payments made to enrollees and the total number and percentage of a carrier's enrollees that participated in such transactions. ***By April 15th of each year, the superintendent shall submit an aggregate report for all carriers filing the information required by this paragraph to the legislative committee having jurisdiction over health insurance matters.***

SUMMARY

This amendment replaces the bill and changes the title. The amendment requires a health care entity to provide an estimate of the allowed amount for a proposed non-emergency admission, procedure or service within 2 business days of a patient's request and to assist a patient in using a carrier's toll-free telephone number and publicly accessible website to obtain information about the out-of-pocket costs for which a patient will be responsible. The allowed amount is the contractually agreed upon amount paid by a carrier to a health care entity participating in a carrier's provider network or the amount a carrier is required to pay to an out-of network health care entity under a health plan policy, contract or certificate before the application of any cost-sharing required to be paid by a patient under a health plan.

The amendment requires health insurance carriers to establish a toll-free telephone number and publicly accessible website to provide information to enrollees about health care costs. A carrier is required to provide information on the average price paid in the past 12 months to a network health care provider for a proposed non-emergency admission, procedure or service in each county and to 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 non-emergency admission, procedure or service that is a medically necessary covered benefit.

The amendment also requires a carrier to pay an enrollee 50% of the saved cost to a maximum of $7,500 if an enrollee shops for and elects to receive health care services from a provider that cost less than the average cost for a particular admission, procedure or service unless the savings is $50 or less. The amendment defines "shoppable" services as services which are high volume, non-urgent procedures and treatments that consumers would plan for and schedule in advance" and authorizes the Bureau of Insurance to amend the definition or define a list of services. If an enrollee elects to receive health care services from an out-of-network provider that cost less than the average amount for a particular admission, procedure or service, a carrier shall apply the enrollee's share of the cost toward the enrollee's member cost sharing as if the health care services were provided by a network provider.

The amendment directs the Maine Health Data Organization to modify its publicly accessible website to include average health care costs by county and to provide confirmation reports to carriers to allow the website to be used as a mechanism for consumer shopping for the shared savings program established in the amendment.

The amendment also requires carriers to provide certain information to the Department of

Professional and Financial Regulation, Bureau of Insurance on an annual basis relating to the payments made to enrollees and the saved costs if an enrollee elects to receive health care services from a provider that cost less than the average cost for a particular admission, procedure or service. The Bureau of Insurance is required to report aggregate information from all carriers to the Legislature on an annual basis as well.

The amendment requires a health care entity to post a notice regarding a consumer's right to shop and also requires a carrier to notify enrollees of their right to shop.