Section 1. Short Title. This Act shall be known and may be cited as the "[STATE] Right to Shop Act."

Section 2. Definitions. As used in this Act, the following definitions apply:

A. "Allowed amount" means the contractually agreed upon amount paid by a carrier to a health care entity participating in the carrier's network or the amount the health plan is required to pay under the health plan policy or Certificate of Insurance for out of network covered benefits provided to the patient.

B. "Health Care Entity" means [insert statutory cross-references for all health care providers licensed in state]

C. "Insurance carrier" means [insert statutory cross-references for all health insurance companies licensed in state, health maintenance organizations, preferred provider arrangement administrators, fraternal benefit societies, nonprofit hospital or medical service organization operating a licensed health plan, self-insured employers subject to state regulation, any other entity offering coverage in the state that is subject to the requirements of PPACA].

D. "Program" means the shared savings incentive program established by a carrier pursuant to this section.

E. "Shoppable health care service" means a health care service for which a carrier offers a shared savings incentive payment under a program established by the carrier pursuant to this section. A shoppable heath care service includes, at a minimum, health care services in the following categories:

(1) Physical and occupational therapy services;

(2) Obstetrical and gynecological services;

(3) Radiology and imaging services;

(4) Laboratory services;

(5) Infusion therapy;

(6) Inpatient/Outpatient Surgical procedures;

(7) Outpatient non-surgical diagnostic tests or procedures.

This list may be expanded by [Insurance Department / Commissioner / Superintendent].

Section 3. Estimate of charges prior to an admission, procedure or service.

A. Prior to a non-emergency admission, procedure or service and upon request by a patient or prospective patient, a health care entity within the patient's or prospective patient's insurer network shall, within 2 working days, disclose the allowed amount of the non-emergency admission, procedure or service, including the amount for any facility fees required.

B. Prior to a non-emergency 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 2 working days, disclose the amount that will be charged for the non-emergency admission, procedure or service, including the amount for any facility fees required.
C. If a health care entity is unable to quote a specific amount under subsection A or subsection B 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 non-emergency admission, procedure or service, including the amount for any facility fees required. A health care entity must 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.
D. If a patient or prospective patient is covered by insurance, a health care entity that participates in a carrier's network shall, upon request of a patient or prospective patient, provide, based on the information available to the health care entity at the time of the request, sufficient information regarding the proposed non-emergency 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, website or access to a third-party service that meets the requirements of this act. A health care entity may assist a patient or prospective patient in using a carrier's toll-free number, website or third-party service.

Section 4. Payment information; availability on website. A carrier shall establish access to an interactive mechanism on its publicly accessible website that enables an enrollee to request and obtain from the carrier, or a designated third-party, information on the payments made by the carrier to network providers for health care services. The interactive mechanism must allow an enrollee seeking information about the cost of a particular health care service to compare costs among network providers as established in section 4, subsection C.

Section 5. Estimate of out-of-pocket costs.
A. Within 2 working days of an enrollee's request, a carrier shall provide a good faith estimate of the allowed amount and 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 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.
B. Nothing in this section shall 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 non-emergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.
C. 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 non-emergency procedure or service.

Section 6. Incentive program required. A carrier shall develop and implement a program that provides incentives for enrollees in a health plan who elect to receive shoppable health care services that are covered by the plan from providers that charge less than the average price paid by that carrier for that shoppable health care service.

A. Incentives may be calculated as a percentage of the difference in price, as a flat dollar amount, or by some other reasonable methodology approved by the [Insurance

Department/Commissioner/Superintendent]. The carrier must provide the incentive as a cash payment to the enrollee.

B. The incentive program must provide enrollees with at least 50% of the carrier's saved costs for each service or category of shoppable 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 $50 or less.

C. A carrier will base the average price on the average paid to an in-network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed 1 year. A carrier may determine an alternate methodology for calculating the average price if approved by the [Insurance Department / Commissioner / Superintendent].

Section 7. Availability of program; notice to enrollees. A 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 to any enrollee who is enrolled in a health plan eligible for the program.

Section 8. Filing with [Insurance Department/Commissioner/Superintendent]**.** 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 [Insurance Department/Commissioner/Superintendent] in the manner determined by the Superintendent. The [Insurance Department/Commissioner/Superintendent] 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 subsection are confidential until the filing has been reviewed or the waiver request has been granted or denied by the [Insurance Department/Commissioner/Superintendent].

Section 9. Out-of-network provider. If an enrollee elects to receive a shoppable health care service from an out-of-network provider that results in a shared savings incentive payment, a carrier shall apply the amount paid for the shoppable health care service toward the enrollee's member cost sharing as specified in the enrollee's health plan as if the health care services were provided by an in-network provider.

Section 10. No administrative expense. A shared savings 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.

Section 11. Report. Annually a carrier shall file with the [Insurance Department/Commissioner/Superintendent] for the most recent calendar year the total number of shared savings incentive payments made pursuant to this section, the use of shoppable health care services by category of service for which shared savings 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 prices by service for such transactions, and the total number and percentage of a carrier's enrollees that participated in such transactions. Beginning April 1, 2018 and annually by April 1st of each year thereafter, the [Insurance Department/Commissioner/Superintendent] 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.

Section 12. Rules. The [Insurance Department/Commissioner/Superintendent] may adopt rules as

necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in [insert applicable statute].

Section 13. This act shall take effect 6 months from the date of enactment.