REFERENCE TITLE: health providers; insurers; estimated costs

State of Arizona
House of Representatives
Fifty-fifth Legislature
Second Regular Session
2022

HB 2486

Introduced by
Representative Wilmeth

AN ACT

AMENDING TITLE 20, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-110, 20-111 AND 20-127; RELATING TO HEALTH CARE SERVICES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 20, chapter 1, article 1, Arizona Revised Statutes, is amended by adding sections 20-110, 20-111 and 20-127, to read:

20-110. Health insurers; interactive mechanism for enrollees; out-of-pocket cost estimate; requirements; definitions

A. BEGINNING JANUARY 1, 2023, A HEALTH INSURER THAT OFFERS A HEALTH CARE PLAN IN THIS STATE SHALL DO ALL OF THE FOLLOWING:

1. ESTABLISH A COMPARABLE HEALTH CARE SERVICE INCENTIVE PROGRAM THAT INCLUDES AN INTERACTIVE MECHANISM ON ITS PUBLICLY ACCESSIBLE WEBSITE OR A TOLL-FREE TELEPHONE NUMBER THAT ENABLES AN ENROLLEE TO REQUEST AND OBTAIN FROM THE HEALTH INSURER INFORMATION ON THE PAYMENTS MADE BY THE HEALTH INSURER TO NETWORK HEALTH CARE FACILITIES OR HEALTH CARE PROVIDERS FOR COMPARABLE HEALTH CARE SERVICES AS WELL AS QUALITY DATA FOR THOSE HEALTH CARE FACILITIES OR HEALTH CARE PROVIDERS TO THE EXTENT AVAILABLE. THE INTERACTIVE MECHANISM OR TOLL-FREE TELEPHONE NUMBER SHALL ALLOW AN ENROLLEE SEEKING INFORMATION ABOUT THE COST OF A PARTICULAR HEALTH CARE SERVICE TO COMPARE ALLOWED AMOUNTS AMONG NETWORK HEALTH CARE FACILITIES OR HEALTH CARE PROVIDERS, ESTIMATE OUT-OF-POCKET COSTS APPLICABLE TO THE ENROLLEE'S HEALTH CARE PLAN AND LEARN THE AVERAGE PAYMENT MADE TO NETWORK HEALTH CARE FACILITIES OR HEALTH CARE PROVIDERS FOR THE PROCEDURE OR HEALTH CARE SERVICE UNDER THE ENROLLEE'S HEALTH CARE PLAN WITHIN A REASONABLE TIME FRAME NOT TO EXCEED ONE YEAR. THE OUT-OF-POCKET COST ESTIMATE SHALL PROVIDE A GOOD FAITH ESTIMATE OF THE AMOUNT THE ENROLLEE WILL BE RESPONSIBLE TO PAY OUT OF POCKET FOR A PROPOSED NONEMERGENCY PROCEDURE OR HEALTH CARE SERVICE THAT IS A MEDICALLY NECESSARY COVERED BENEFIT FROM A HEALTH INSURER'S NETWORK HEALTH CARE FACILITY OR HEALTH CARE PROVIDER, INCLUDING ANY COPAYMENT, DEDUCTIBLE, COINSURANCE OR OTHER OUT-OF-POCKET AMOUNT FOR ANY COVERED BENEFIT, BASED ON THE INFORMATION AVAILABLE TO THE HEALTH INSURER AT THE TIME THE ENROLLEE MAKES THE REQUEST. A HEALTH INSURER MAY CONTRACT WITH A THIRD-PARTY VENDOR TO SATISFY THE REQUIREMENTS OF THIS PARAGRAPH.

2. NOTIFY AN ENROLLEE MAKING A REQUEST UNDER PARAGRAPH 1 OF THIS SUBSECTION THAT THESE ARE ESTIMATED COSTS AND THAT THE ACTUAL TOTAL COST OF CARE AND TOTAL OUT-OF-POCKET COSTS MAY BE MORE OR LESS DEPENDING ON THE EXACT CIRCUMSTANCES OF THE CARE AND TREATMENT PROVIDED, THE ENROLLEE'S DECISIONS AND CHOICES AND UNANTICIPATED OR UNFORESEEN ISSUES DIRECTLY OR INDIRECTLY RELATED TO THE ENROLLEE'S MEDICAL CONDITION.

B. SUBSECTION A OF THIS SECTION DOES NOT PROHIBIT A HEALTH INSURER FROM IMPOSING COST SHARING REQUIREMENTS DISCLOSED IN AN ENROLLEE'S CONTRACT OR POLICY 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 OUT-OF-POCKET COST ESTIMATE.

C. A HEALTH INSURER, ANNUALLY AT ENROLLMENT OR RENEWAL, SHALL PROVIDE NOTICE ABOUT THE AVAILABILITY OF A TOLL-FREE TELEPHONE NUMBER AND ANY INTERACTIVE MECHANISM TO COMPARE ALLOWED AMOUNTS AMONG NETWORK HEALTH CARE FACILITIES OR HEALTH CARE PROVIDERS AND TO EACH ENROLLEE WHO IS ENROLLED IN A HEALTH CARE PLAN THAT IS ELIGIBLE.

D. BEFORE OFFERING THE PROGRAM TO ANY ENROLLEE, A HEALTH INSURER SHALL FILE A DESCRIPTION OF THE PROGRAM ESTABLISHED BY THE HEALTH INSURER PURSUANT TO THIS SECTION WITH THE DEPARTMENT. HEALTH INSURERS MAY OFFER THE PROGRAM TO ENROLLEES THAT RECEIVE A PREMIUM SUBSIDY UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148).

E. FOR THE PURPOSES OF THIS SECTION:

1. "ALLOWED AMOUNT" MEANS THE CONTRACTUALLY AGREED ON AMOUNT PAID BY A HEALTH INSURER TO A HEALTH CARE PROVIDER OR HEALTH CARE FACILITY PARTICIPATING IN THE HEALTH INSURER'S NETWORK OR THE AMOUNT THE HEALTH INSURER IS REQUIRED TO PAY UNDER THE HEALTH CARE PLAN.

2. "COMPARABLE HEALTH CARE SERVICES" MEANS ANY COVERED NONEMERGENCY HEALTH CARE SERVICE OR BUNDLE OF SERVICES, INCLUDING AT LEAST THE FOLLOWING:

(a) PHYSICAL AND OCCUPATIONAL THERAPY SERVICES.

(b) OBSTETRICAL AND GYNECOLOGICAL SERVICES.

(c) RADIOLOGY AND IMAGING SERVICES.

(d) LABORATORY SERVICES.

(e) INFUSION THERAPY.

(f) INPATIENT AND OUTPATIENT SURGICAL PROCEDURES.

3. "ENROLLEE" MEANS A PERSON WHO IS ENROLLED IN A HEALTH CARE PLAN PROVIDED BY A HEALTH INSURER.

4. "HEALTH CARE FACILITY" HAS THE SAME MEANING PRESCRIBED IN SECTION 36-437.

5. "HEALTH CARE PLAN":

(a) MEANS A POLICY, CONTRACT OR EVIDENCE OF COVERAGE ISSUED TO AN ENROLLEE.

(b) DOES NOT INCLUDE LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137 OR COVERAGE OFFERED THROUGH A MEDICARE ACCOUNTABLE CARE ORGANIZATION.

6. "HEALTH CARE PROVIDER" HAS THE SAME MEANING PRESCRIBED IN SECTION 32-3216.

7. "HEALTH CARE SERVICE" MEANS ANY HEALTH-RELATED SERVICE OR TREATMENT, TO THE EXTENT THAT THE SERVICE OR TREATMENT IS ALLOWED OR NOT PROHIBITED BY LAW OR REGULATION, THAT MAY BE PROVIDED BY A PERSON OR BUSINESS THAT IS OTHERWISE ALLOWED TO OFFER THE SERVICE OR TREATMENT.

8. "HEALTH INSURER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-111.

9. "PROGRAM" MEANS THE COMPARABLE HEALTH CARE SERVICE INCENTIVE PROGRAM ESTABLISHED BY A HEALTH INSURER PURSUANT TO THIS SECTION.

10. "TOTAL COST OF CARE" MEANS THE COMBINED COST OF INPATIENT AND OUTPATIENT COVERED HEALTH CARE SERVICES.

11. "TOTAL OUT-OF-POCKET COSTS" MEANS THE SUM OF ALL COPAYMENTS, COINSURANCE AND DEDUCTIBLES AND ANY OTHER PATIENT PAYMENT RESPONSIBILITY THAT IS DUE UNDER THE TERMS OF THE HEALTH CARE PLAN.

20-111. Health insurers; shared savings programs; definitions

A. BEGINNING WITH THE NEXT HEALTH INSURANCE RATE FILING AFTER THE EFFECTIVE DATE OF THIS SECTION, A HEALTH INSURER THAT OFFERS A HEALTH CARE PLAN IN THIS STATE SHALL ESTABLISH FOR ALL HEALTH CARE PLANS IT OFFERS IN THIS STATE IN THE INDIVIDUAL AND SMALL GROUP MARKET AND THAT ARE NOT OFFERED ON A HEALTH CARE EXCHANGE A SHARED SAVINGS PROGRAM IN WHICH ENROLLEES ARE DIRECTLY INCENTIVIZED TO SHOP BEFORE AND AFTER THE ENROLLEE'S OUT-OF-POCKET LIMIT HAS BEEN MET FOR CARE PROVIDED BY IN-NETWORK HEALTH CARE PROVIDERS OR HEALTH CARE FACILITIES FOR COMPARABLE HEALTH CARE SERVICES LESS THAN THE AVERAGE AMOUNT PAID BY THE HEALTH INSURER. SHARED SAVINGS INCENTIVES MAY BE CALCULATED AS A PERCENTAGE OF THE DIFFERENCE IN ALLOWED AMOUNTS TO THE AVERAGE, OR A FLAT DOLLAR AMOUNT, OR BY SOME OTHER REASONABLE METHODOLOGY APPROVED BY THE DEPARTMENT. INCENTIVES MAY INCLUDE CASH PAYMENTS, GIFT CARDS OR CREDITS OR REDUCTIONS OF PREMIUMS, COPAYMENTS, COINSURANCE OR DEDUCTIBLES.

B. A HEALTH INSURER, ANNUALLY AT ENROLLMENT OR RENEWAL, SHALL PROVIDE NOTICE ABOUT THE AVAILABILITY OF THE SHARED SAVINGS PROGRAM TO EACH ENROLLEE WHO IS ENROLLED IN A HEALTH CARE PLAN THAT IS ELIGIBLE FOR THE PROGRAM. AN INCENTIVE MADE BY A HEALTH INSURER IN ACCORDANCE WITH THIS SECTION IS NOT AN ADMINISTRATIVE EXPENSE OF THE HEALTH INSURER FOR RATE DEVELOPMENT OR RATE FILING PURPOSES.

C. FOR THE PURPOSES OF THIS SECTION:

1. "HEALTH CARE FACILITY" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-110.

2. "HEALTH CARE PLAN" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-110.

3. "HEALTH CARE PROVIDER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-110.

4. "HEALTH CARE SERVICES" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-110.

5. "HEALTH INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES CORPORATION, OR HOSPITAL AND MEDICAL SERVICE CORPORATION.

20-127. Patient access to lower costs; annual report

A. BEGINNING ON APPROVAL OF THE NEXT HEALTH INSURANCE RATE FILING AFTER THE EFFECTIVE DATE OF THIS SECTION, IF AN ENROLLEE ELECTS TO OBTAIN A COVERED HEALTH CARE SERVICE FROM A UNITED STATES BASED OUT-OF-NETWORK PROVIDER AT A COST THAT IS THE SAME OR LESS THAN THE IN-NETWORK AVERAGE THAT AN ENROLLEE'S HEALTH INSURER PAYS FOR THAT SERVICE WITHIN A REASONABLE TIME FRAME, NOT TO EXCEED ONE YEAR, AND ON REQUEST BY THE

ENROLLEE, THE HEALTH CARE PLAN SHALL APPLY THE PAYMENT MADE, OR REQUIRED, 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 CARE PLAN AS IF THE HEALTH CARE SERVICES HAD BEEN PROVIDED BY A NETWORK PROVIDER. THE HEALTH INSURER 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. AT A MINIMUM, A HEALTH INSURER SHALL INFORM ITS ENROLLEES OF THEIR OPTIONS UNDER THIS SECTION AND THE PROCESS TO REQUEST THE AVERAGE ALLOWED AMOUNT PAID FOR A PROCEDURE OR SERVICE. THE HEALTH INSURER SHALL MAKE THIS INFORMATION AVAILABLE ON ITS WEBSITE AND IN ITS BENEFIT PLAN MATERIALS. A HEALTH INSURER MAY INFORM ENROLLEES THAT THE HEALTH INSURER CANNOT CERTIFY THE QUALITY OF CARE PROVIDED BY AN OUT-OF-NETWORK PROVIDER AND THAT THE COST SAVING BENEFIT MAY ONLY BE REALIZED IF THE COSTS ARE BELOW OR THE SAME AS THE IN-NETWORK AVERAGE.

C. BEGINNING ON APPROVAL OF THE NEXT HEALTH INSURANCE RATE FILING AFTER THE EFFECTIVE DATE OF THIS SECTION, A HEALTH INSURER MAY NOT DENY PAYMENT FOR ANY IN-NETWORK HEALTH CARE SERVICE COVERED UNDER AN ENROLLEE'S HEALTH CARE PLAN BASED SOLELY ON THE BASIS THAT THE ENROLLEE'S REFERRAL WAS MADE BY A PROVIDER WHO IS NOT A MEMBER OF THE HEALTH INSURER'S PROVIDER NETWORK.

D. BEGINNING MARCH 1, 2023 AND ANNUALLY THEREAFTER, THE DIRECTOR SHALL CONDUCT A STUDY AND EVALUATION OF THE PROGRAMS ESTABLISHED BY HEALTH INSURER'S PURSUANT TO THIS SECTION. THE DIRECTOR MAY REQUEST INFORMATION ON ENROLLMENT AND THE USE OF INCENTIVES EARNED BY ENROLLEES. ON OR BEFORE APRIL 15, 2023 AND ANNUALLY THEREAFTER, THE DIRECTOR SHALL SUBMIT AN AGGREGATE REPORT RELATING TO THE PERFORMANCE OF THE PROGRAMS, THE USE OF INCENTIVES, THE INCENTIVES EARNED BY ENROLLEES AND THE CUMULATIVE EFFECT OF THE PROGRAMS TO THE CHAIRPERSONS OF THE HEALTH AND HUMAN SERVICES COMMITTEES IN THE SENATE AND THE HOUSE OF REPRESENTATIVES OR THEIR SUCCESSOR COMMITTEES.

Sec. 2. Short title

This act may be cited as the "Right To Shop Act of 2022".