SENATE BILL NO. 119

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTIETH LEGISLATURE - FIRST SESSION

BY SENATOR HUGHES

Introduced: 4/24/17
Referred: Labor and Commerce, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to disclosure of health care services and price information; relating to health care insurers; relating to availability of payment information and estimates of out-of-pocket expenses; relating to an incentive program for electing to receive health care services for less than the average price paid; relating to filing and reporting requirements; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SHORT TITLE. This Act may be known as the Alaska Health Care Consumer's Right to Shop Act.

*** Sec. 2.** AS 18.15.360(a) is amended to read:

(a) The department is authorized to collect, analyze, and maintain databases of information related to

(1) risk factors identified for conditions of public health importance;

(2) morbidity and mortality rates for conditions of public health importance;

(3) community indicators relevant to conditions of public health importance;

(4) longitudinal data on traumatic or acquired brain injury from the registry established under AS 47.80.500(c)(1); [AND]

(5) **health care services and price information collected under AS 18.23.400; and**

(6) any other data needed to accomplish or further the mission or goals of public health or provide essential public health services and functions.

*** Sec. 3.** AS 18.23 is amended by adding new sections to read:

Article 4. Health Care Services and Price Information.

Sec. 18.23.400. Disclosure and reporting of health care services and price information. (a) A health care provider in the state and a health care facility in the state shall annually compile a list, by procedure code, including a brief and easily understandable description, of the top 25 health care services from each of the six sections of Category I, Current Procedural Terminology, adopted by the American Medical Association that a prudent person would consider of value in the management of their own affairs and the price for each service, including any discounts that may be applicable.

(b) A health care provider and health care facility shall publish the lists compiled under (a) of this section by January 31 each year

(1) by providing the list to the department for posting on the department's public database under AS 18.15.360;

(2) by posting a copy of the list in a conspicuous public reception area at the health care provider's office or health care facility where the services are performed; and

(3) if the health care provider or health care facility has an Internet website, by posting the list on the website.

(c) A health care provider and health care facility may include a disclaimer in

the publication under (b) of this section that explains that the price paid by the patient may be higher or lower than the amount listed.

(d) The department shall compile and annually update the lists provided under (a) of this section by health care service and, where relevant, health care provider and health care facility name and location, and post the information on the department's Internet website and enter the information in the database maintained under AS 18.15.360.

(e) If a health care provider or health care facility in the state performs fewer than 25 health care services in the state from each of the six sections of Category I, Current Procedural Terminology, adopted by the American Medical Association in the annual reporting period under this section, the provider or facility shall provide a list of all of the health care services from each of the six sections of Category I, Current Procedural Terminology, performed by the provider or at the facility.

(f) A health care provider or health care facility that fails to comply with the requirements of this section is liable for a civil penalty. The department may impose a civil penalty of not more than $50 for each day after March 31 that a health care provider or health care facility fails to provide and post information as required under (b) of this section. The total penalty may not exceed $2,500. A person penalized under this subsection may file an appeal with the superior court for judicial review of the penalty under AS 44.62.560.

Sec. 18.23.405. Cost estimates for health care services. (a) Upon written request of a patient or the patient's authorized agent, a health care provider shall provide the patient or agent with a comprehensive, good faith estimate of the total charges for a health care service that the patient is receiving or has been recommended to receive if the total charges exceed $250. The health care provider shall provide the estimate of total charges within five business days after receiving the written request and any additional information needed to provide a comprehensive estimate of total charges.

(b) The estimate of total charges must indicate,

(1) if known, the network status of the health care provider under an insured patient's health care insurance plan;

(2) if known, whether the health care services of another health care provider are necessary or recommended to complete the health care service being recommended or provided; and

(3) if health care services from another provider are necessary or recommended for the health care service being recommended or provided, that the patient or the patient's authorized agent must make a separate request to the other health care provider for

(A) an estimate of the charges for health care services to be provided by the other health care provider; and

(B) information on the network status of the other health care provider under an insured patient's health care insurance plan.

(c) If the patient is uninsured, the health care provider shall

(1) include in the estimate of total charges any financial assistance available to the patient from the health care provider; and

(2) direct the patient or the patient's authorized agent to Internet websites, if available, that provide information about standard charges for the type of health care provider that provides the health care service.

(d) The patient or the patient's authorized agent may request that the information required under this section be provided in writing or electronically.

(e) The estimate of total charges

(1) must represent a good faith effort to provide accurate information to the patient or the patient's authorized agent;

(2) is not a binding contract between the parties; and

(3) is not a guarantee that the estimate of total charges will be the amount actually charged or will account for unforeseen conditions.

(f) This section does not apply to health care services provided for the treatment of an emergency medical condition or for the treatment of an emergency medical condition that results in hospitalization.

Sec. 18.23.420. Definitions. In AS 18.23.400 - 18.23.420,

(1) "department" means the Department of Health and Social Services;

(2) "emergency medical condition" has the meaning given in

AS 21.07.250;

(3) "health care facility" means a private, municipal, state, or federal hospital, psychiatric hospital, independent diagnostic testing facility, residential psychiatric treatment center as defined in AS 47.32.900, tuberculosis hospital, kidney disease treatment center (including freestanding hemodialysis units), the offices of private physicians or dentists whether in individual or group practice, an ambulatory surgical center as defined in AS 47.32.900, a free-standing birth center as defined in AS 47.32.900, and a rural health clinic as defined in AS 47.32.900; "health care facility" does not include an Alaska tribal health organization or another federally operated hospital or facility;

(4) "health care insurance plan" has the meaning given in AS 21.54.500;

(5) "health care provider" means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care services in the ordinary course of business or practice of a profession;

(6) "health care service" means a service or procedure provided in person or remotely by telehealth or other means by a health care provider or at a health care facility for the purpose of or incidental to the care, prevention, or treatment of a physical or mental illness or injury;

(7) "price" means the charges billed directly to a recipient for services rendered without complications or exceptional circumstances; "price" does not include a negotiated discount for in-network, out-of-network, or self-insured services rendered or the costs paid by a third party for those services;

(8) "recipient" means an individual to whom health care services are provided in the state by a health care provider or at a health care facility;

(9) "telehealth" has the meaning given in AS 47.05.270(e);

(10) "third party" means a public or private entity, association, or organization that provides, by contract, agreement, or other arrangement, insurance, payment, price discount, or other benefit for all or a portion of the cost of health care services provided to a recipient; "third party" does not include a member of the recipient's immediate family.

*** Sec. 4.** AS 21.06.110 is amended to read:

Sec. 21.06.110. Director's annual report. As early in each calendar year as is reasonably possible, the director shall prepare and deliver an annual report to the commissioner, who shall notify the legislature that the report is available, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in this state, with a summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose certificate of authority was surrendered, suspended, or revoked during the year and the cause of surrender, suspension, or revocation;

(3) the name of each insurer authorized to do business in this state against which delinquency or similar proceedings were instituted and, if against an insurer domiciled in this state, a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the **receipts** [RECEIPT] and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance or the office of director;

(7) statistical information regarding health insurance, including the number of individual and group policies sold or terminated in the state; this paragraph does not authorize the director to require an insurer to release proprietary information;

(8) the annual percentage of health claims paid in the state that meets the requirements of AS 21.36.495(a) and (d);

(9) the total amount of contributions reported and the total amount of credit claimed under AS 21.96.070 and 21.96.075;

(10) the total number of public comments received and the director's efforts, to the extent allowable by law, to improve or maintain public access to information on individual health insurance rate filings before they become effective; [AND]

(11) **the most recent incentive program report compiled under AS 21.96.235; and**

(12) other pertinent information and matters the director considers proper.

*** Sec. 5.** AS 21.96 is amended by adding new sections to read:

Sec. 21.96.200. Access to payment information. A health care insurer shall establish an interactive mechanism for use by a covered person on the publicly accessible Internet website of the health care insurer that allows a covered person to request and obtain from the health care insurer, or a designated third party, information on the payments made by the health care insurer to network health care providers for health care services. The interactive mechanism must allow a covered person seeking information about the cost of a particular health care service to compare prices among network health care providers for the incentive program under AS 21.96.210.

Sec. 21.96.205. Estimate of out-of-pocket expenses. (a) Upon request of a covered person, within five working days, a health care insurer shall disclose a good faith estimate of the amount of out-of-pocket expenses that the covered person will be responsible to pay for a nonemergency health care service that is a medically necessary benefit covered by the health care insurance plan of the covered person, including any copayment, coinsurance, or other out-of-pocket amount, based on the information available to the health care insurer at the time of the request.

(b) Nothing in this section prohibits a health care insurer from imposing the cost-sharing requirements disclosed under the health care insurance plan of the covered person for unforeseen health care services or additional costs that arise out of the nonemergency health care service or services that were not included in the estimate provided under (a) of this section.

(c) The health care insurer shall disclose to the covered person that an estimate provided under (a) of this section is an estimated cost and that the actual amount that the covered person will be responsible to pay may vary because of unforeseen health care services or additional costs that arise out of the nonemergency health care service or services.

Sec. 21.96.210. Incentive program. (a) A health care insurer shall develop and implement a program that provides an incentive for a covered person enrolled in a health care insurance plan to elect to receive a health care service that is covered under the health care insurance plan from a health care provider that charges less than the average price paid by the health care insurer for that health care service. At a minimum, a health care insurer shall include the following categories of health care services, and any other categories adopted by the director by regulation, in the health care insurer's incentive program:

(1) physical and occupational therapy services;

(2) obstetrical and gynecological services;

(3) radiology and imaging services;

(4) laboratory services;

(5) infusion therapy;

(6) dental services;

(7) vision services;

(8) behavioral health services;

(9) inpatient or outpatient surgical procedures; and

(10) outpatient nonsurgical diagnostic tests or procedures.

(b) A health care insurer shall provide an incentive as a cash payment to the covered person as provided under this subsection. An incentive may be calculated as a percentage of the difference in price, as a flat dollar amount, or by some other reasonable methodology adopted by regulation. If a covered person receives coverage under a group health insurance policy offered by an employer, an incentive must provide a covered person with at least 33.4 percent of the savings for the health care insurer resulting from the covered person's election to receive a health care service from a health care provider that charges less than the average price paid by the health care insurer for that health care service, and the employer shall receive at least 33.3 percent of the savings resulting from the covered person's election. If a covered person receives coverage under a health insurance policy offered in the individual market, an incentive must provide a covered person with at least 50 percent of the savings for the health care insurer resulting from the covered person's election.

(c) A health care insurer shall base the average price for a health care service under this section on the average amount paid to in-network health care providers for the health care service within a reasonable period of time, but not to exceed one year.

Sec. 21.96.215. Availability of program; notice. A health care insurer shall make an incentive program under AS 21.96.210 available as a component of all health care insurance plans offered in this state. Annually, at enrollment or renewal, a health care insurer shall provide notice about the availability of the program to any person covered under a health care insurance plan eligible for the program.

Sec. 21.96.220. Filing requirements. Before offering an incentive program under AS 21.96.210, a health care insurer shall file a description of the program with the director in the manner determined by the director. The director may review the filing to determine whether the incentive program complies with the requirements of AS 21.96.200 - 21.96.300.

Sec. 21.96.225. Out-of-network health care providers. If a covered person participates in an incentive program under AS 21.96.210 and elects to receive a health care service listed under AS 21.96.210(a) from an out-of-network health care provider that results in a savings for the health care insurer, the health care insurer shall apply the amount paid for the health care service toward the cost sharing owed by the covered person as specified in the applicable health care insurance plan as if the health care services were provided by an in-network health care provider.

Sec. 21.96.230. Classification as administrative expense. An incentive program payment made under AS 21.96.210 is not an administrative expense of the health care insurer for rate development or rate filing purposes.

Sec. 21.96.235. Reporting requirements. (a) A health care insurer shall annually file a report with the director relating to an incentive program under AS 21.96.210 for the most recent calendar year that includes

(1) the total number of incentive program payments;

(2) information on the use of the incentive program by category of service;

(3) the total amount of incentive program payments;

(4) the average amount of each incentive program payment for each

category of service;

(5) the total savings achieved below the average price of the health care service in each category of service; and

(6) the total number and percentage of covered persons who participated in the incentive program.

(b) Annually, by April 1, beginning April 1, 2019, the director shall submit an aggregate report for all health care insurers with the information required under (a) of this section to the chairs of the committee in each house of the legislature with jurisdiction over labor and commerce.

Sec. 21.96.300. Definitions. In AS 21.96.200 - 21.96.300,

(1) "emergency medical condition" has the meaning given in AS 21.07.250;

(2) "health care insurance plan" has the meaning given in AS 21.54.500;

(3) "health care insurer" has the meaning given in AS 21.54.500;

(4) "health care provider" has the meaning given in AS 18.23.420;

(5) "health care service" has the meaning given in AS 18.23.420;

(6) "nonemergency" does not include treatment of an emergency medical condition.

*** Sec. 6.** AS 29.10.200 is amended by adding a new paragraph to read:

(66) AS 29.35.142 (disclosure and reporting of health care services and price information).

*** Sec. 7.** AS 29.35 is amended by adding a new section to read:

Sec. 29.35.142. Regulation of disclosure and reporting of health care services and price information. (a) The authority to regulate the disclosure or reporting of price information for health care services by health care providers, health care facilities, or health care insurers is reserved to the state, and, except as specifically provided by statute, a municipality may not enact or enforce an ordinance regulating the disclosure or reporting of price information for health care services by health care providers, health care facilities, or health care insurers.

(b) This section applies to home rule and general law municipalities.

(c) In this section,

(1) "health care facility" has the meaning given in AS 18.23.420;

(2) "health care insurer" has the meaning given in AS 21.54.500;

(3) "health care provider" has the meaning given in AS 18.23.420;

(4) "health care service" has the meaning given in AS 18.23.420.

*** Sec. 8.** AS 39.30.090(a) is amended to read:

(a) The Department of Administration may obtain a policy or policies of group insurance covering state employees, persons entitled to coverage under AS 14.25.168, 14.25.480, AS 22.25.090, AS 39.35.535, 39.35.880, or former AS 39.37.145, employees of other participating governmental units, or persons entitled to coverage under AS 23.15.136, subject to the following conditions:

(1) a group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audiovisual insurance, or other medical care insurance;

(2) each eligible employee of the state, the spouse and the unmarried children chiefly dependent on the eligible employee for support, and each eligible employee of another participating governmental unit shall be covered by the group policy, unless exempt under regulations adopted by the commissioner of administration;

(3) a governmental unit may participate under a group policy if

(A) its governing body adopts a resolution authorizing participation and payment of required premiums;

(B) a certified copy of the resolution is filed with the Department of Administration; and

(C) the commissioner of administration approves the participation in writing;

(4) in procuring a policy of group health or group life insurance as provided under this section or excess loss insurance as provided in AS 39.30.091, the Department of Administration shall comply with the dual choice requirements of AS 21.86.310, and shall obtain the insurance policy from an insurer authorized to

transact business in the state under AS 21.09, a hospital or medical service corporation authorized to transact business in this state under AS 21.87, or a health maintenance organization authorized to operate in this state under AS 21.86; an excess loss insurance policy may be obtained from a life or health insurer authorized to transact business in this state under AS 21.09 or from a hospital or medical service corporation authorized to transact business in this state under AS 21.87;

(5) the Department of Administration shall make available bid specifications for desired insurance benefits or for administration of benefit claims and payments to (A) all insurance carriers authorized to transact business in this state under AS 21.09 and all hospital or medical service corporations authorized to transact business under AS 21.87 who are qualified to provide the desired benefits; and (B) insurance carriers authorized to transact business in this state under AS 21.09, hospital or medical service corporations authorized to transact business under AS 21.87, and third-party administrators licensed to transact business in this state and qualified to provide administrative services; the specifications shall be made available at least once every five years; the lowest responsible bid submitted by an insurance carrier, hospital or medical service corporation, or third-party administrator with adequate servicing facilities shall govern selection of a carrier, hospital or medical service corporation, or third-party administrator under this section or the selection of an insurance carrier or a hospital or medical service corporation to provide excess loss insurance as provided in AS 39.30.091;

(6) if the aggregate of dividends payable under the group insurance policy exceeds the governmental unit's share of the premium, the excess shall be applied by the governmental unit for the sole benefit of the employees;

(7) a person receiving benefits under AS 14.25.110, AS 22.25, AS 39.35, or former AS 39.37 may continue the life insurance coverage that was in effect under this section at the time of termination of employment with the state or participating governmental unit;

(8) a person electing to have insurance under (7) of this subsection shall pay the cost of this insurance;

(9) for each permanent part-time employee electing coverage under

this section, the state shall contribute one-half the state contribution rate for permanent full-time state employees, and the permanent part-time employee shall contribute the other one-half;

(10) a person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain auditory, visual, and dental insurance for that person and eligible dependents under this section; the level of coverage for persons over 65 shall be the same as that available before reaching age 65 except that the benefits payable shall be supplemental to any benefits provided under the federal old age, survivors, and disability insurance program; a person electing to have insurance under this paragraph shall pay the cost of the insurance; the commissioner of administration shall adopt regulations implementing this paragraph;

(11) a person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain long-term care insurance for that person and eligible dependents under this section; a person who elects insurance under this paragraph shall pay the cost of the insurance premium; the commissioner of administration shall adopt regulations to implement this paragraph;

(12) each licensee holding a current operating agreement for a vending facility under AS 23.15.010 - 23.15.210 shall be covered by the group policy that applies to governmental units other than the state**;**

(13) a group health insurance policy covering employees of a participating governmental unit is subject to the requirements under AS 18.23.400, 18.23.405, and AS 21.96.200 - 21.96.300.

*** Sec. 9.** AS 39.30.091 is amended to read:

Sec. 39.30.091. Authorization for self-insurance and excess loss insurance. Notwithstanding AS 21.86.310 or AS 39.30.090, the Department of Administration may provide, by means of self-insurance, one or more of the benefits listed in AS 39.30.090(a)(1) for state employees eligible for the benefits by law or under a collective bargaining agreement and for persons receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37, and their dependents. The department shall procure any necessary excess loss insurance under AS 39.30.090. **A group health insurance policy provided under this section covering employees of a**

participating governmental unit is subject to the requirements under AS 18.23.400, 18.23.405, and AS 21.96.200 - 21.96.300.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Commerce, Community, and Economic Development may adopt regulations necessary to implement this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the law implemented by the regulation.

*** Sec. 11.** Section 10 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 12.** Except as provided in sec. 11 of this Act, this Act takes effect January 1, 2018.