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An Act To Encourage Health Insurance Consumers To Comparison Shop for Health Care Procedures and Treatment

Be it enacted by the People of the State of Maine as follows:

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

C. "Allowed amount" means the contractually agreed upon amount paid by a carrier to a health care entity for health care services provided to a patient covered by insurance.

Sec. 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 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. 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. 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. 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 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 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 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. An enrollee may not be required to pay more than the disclosed amounts for the covered 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 admission, procedure or service. 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 health plan.

C. If an enrollee elects to receive 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. 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.

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 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.

SUMMARY

This bill requires a health care entity to provide an estimate of the allowed amount if the entity is within a patient's carrier network or the amount that will be charged if the entity does not participate in a patient's carrier network for a proposed 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 bill 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 admission, procedure or service in each geographic rating area established by the carrier 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 admission, procedure or service that is a medically necessary covered benefit.

The bill also requires a carrier to pay an enrollee 50% of the saved cost to a maximum of \$7,500 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 unless the savings is \$50 or less. 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 bill authorizes a health care entity, a carrier or another person designated by a health care entity, carrier, patient or prospective patient to have access at no cost to the all-payor and all-settings health care database for claims for the purposes of providing the information required.

The bill 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.