Are State Public Option Health Plans Worth It?

SB 204 (see companion bill HB 1075)

Health care provider panels; vertically integrated Health care provider panels; vertically integrated carriers; reimbursements to providers. Requires any vertically integrated carrier, upon written request, to offer participation in each requested provider panel or network established for each of the vertically integrated carrier's policies, products, and plans, including all policies, products, and plans offered to individuals, employers, and enrollees in government benefit programs, to the requesting provider under the same terms and conditions that apply to providers under common control with the vertically integrated carrier. The measure requires that the offered participation (i) be without any adverse tiering or other financial incentives that may discourage enrollees from utilizing the services of the provider, (ii) include all sites and services offered by the provider, and (iii) take into account the different characteristics of different providers with regard to the range, nature, cost, and complexity of services offered. The measure prohibits an officer or director of a vertically integrated carrier from simultaneously serving as an officer or director of an entity that owns, operates, manages, or controls an acute care hospital located, in whole or in part, in the Commonwealth. The measure defines "vertically integrated carrier" as a health insurer or other carrier that owns an interest in, is owned by, or is under common ownership or control with an acute care hospital facility, excluding an entity that is under the ultimate control of or under common control with a public hospital. If a provider panel contract between a provider and a carrier, or other entity that provides hospital, physician or other health care services to a carrier, includes provisions that require a provider, as a

condition of participating in one of the carrier's or other entity's provider panels, to participate in any other provider panel owned or operated by that carrier or other entity, the contract shall contain a provision permitting the provider to refuse participation in one or more such other provider panels at the time the contract is executed.

HB 1075 (see companion bill SB 204)

Health care provider panels; vertically integrated Health care provider panels; vertically integrated carriers; reimbursements to providers. Requires any vertically integrated carrier, upon written request, to offer participation in each requested provider panel or network established for each of the vertically integrated carrier's policies, products, and plans, including all policies, products, and plans offered to individuals, employers, and enrollees in government benefit programs, to the requesting provider under the same terms and conditions that apply to providers under common control with the vertically integrated carrier. The measure requires that the offered participation (i) be without any adverse tiering or other financial incentives that may discourage enrollees from utilizing the services of the provider, (ii) include all sites and services offered by the provider, and (iii) take into account the different characteristics of different providers with regard to the range, nature, cost, and complexity of services offered. The measure prohibits an officer or director of a vertically integrated carrier from simultaneously serving as an officer or director of an entity that owns, operates, manages, or controls an acute care hospital located, in whole or in part, in the Commonwealth. The measure defines "vertically integrated carrier" as a health insurer or other carrier that owns an interest in, is owned by, or is under common ownership or control with an acute care hospital facility, excluding an entity that is under the ultimate control of or under common control with a public hospital. If a provider panel contract between a provider and a carrier, or other entity that provides hospital, physician or other

health care services to a carrier, includes provisions that require a provider, as a condition of participating in one of the carrier's or other entity's provider panels, to participate in any other provider panel owned or operated by that carrier or other entity, the contract shall contain a provision permitting the provider to refuse participation in one or more such other provider panels at the time the contract is executed.

Healthcare Affordability State Policy Scorecard

SB 573

Health plans; calculation of enrollee's contribution to out-of-pocket maximum or cost-sharing requirement; rebates. Requires any carrier issuing a health plan in the Commonwealth to count the amount of any rebates received or to be received by the carrier or its pharmacy benefits manager in connection with the dispensing or administration of a prescription drug when calculating the enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under the carrier's health plan.

HB 1094

Certificate of public need; exception; physician-owned ambulatory surgery center. Exempts physician-owned ambulatory surgery centers, as that term is defined in the bill, from the requirement of obtaining a certificate of public need before undertaking a project.

HB 526

Coverage for reproductive health services. Requires health benefit plans to cover the costs of specified health care services, drugs, devices, products, and procedures related to reproductive health, including (i) well-woman preventive visits; (ii) counseling for sexually transmitted infections; (iii) screening for certain conditions; (iv) folic acid supplements; (v) breastfeeding support, counseling, and supplies; (vi) breast cancer chemoprevention counseling; (vii) contraceptive drugs, devices, or products; (viii) voluntary sterilization; and (ix) any additional preventive services for women that must be covered without cost sharing under federal law as of January 1, 2019. The mandated coverage does not include abortion services other than when performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when the pregnancy is the result of an alleged act of rape or incest. The measure provides an exemption for plans sold to religious employers. Carriers are prohibited from excluding a covered person from participating in, being denied the benefits of, or otherwise being subjected to discrimination in the coverage of or payment for reproductive health services, and a violation constitutes an unfair trade practice. The health benefit plan requirements become effective when a plan is delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the health benefit plan is changed or any premium adjustment is made.

HB 1445

Reproductive health services. Requires health benefit plans to cover the costs of specified health care services, drugs, devices, products, and procedures related to reproductive health. The health benefit plan requirements become effective when a plan is delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the health benefit plan is changed or any premium adjustment is made. The measure also requires the Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of the costs of a reproductive health care program providing reimbursement for medically necessary reproductive health care services, drugs, devices, products, and procedures for eligible individuals.

SB 917

Reproductive health services. Requires health benefit plans to cover the costs of specified health care services, drugs, devices, products, and procedures related to reproductive health. The health benefit plan requirements become effective when a plan is delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the health benefit plan is changed or any premium adjustment is made. The measure also requires the Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of the costs of a reproductive health care program providing reimbursement for medically necessary reproductive health care services, drugs, devices, products, and procedures for eligible individuals.

HB 2274

Health insurance; provider contracts. Requires that each provider contract include provisions (i) requiring providers to provide health care services to enrollees in a manner similar to and within the same time availability in which the provider provides health care services to any other individual and (ii) prohibiting a provider from discriminating against any enrollee as a result of the enrollee's enrollment in a health plan or on the basis of the enrollee's race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health care services, status as a litigant except in cases where the enrollee claims medical malpractice by the provider, status as a Medicare enrollee, status as a medical assistance recipient, sexual orientation, or gender identity, or on any other basis prohibited by law. The bill prohibits a provider contract from requiring a provider to provide any type or kind of health care service to enrollees that it does not customarily provide to others. The bill provides that a provider that violates the anti-discrimination provisions may be subject to fines and other discipline from the provider's licensing authority and an enrollee injured as result of any discrimination is entitled initiate a civil action against the provider.

The bill also prohibits a provider contract from (a) directly or indirectly restricting the carrier from directing or steering enrollees to other health care providers or offering incentives to encourage enrollees to utilize specific providers; (b) requiring the carrier to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider or to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved; or (c) restricting other carriers not party to the contract from paying a lower rate for items or services than the contracting plan or issuer pays for such items or services.

The bill prohibits a provider from terminating or failing to renew the contractual relationship with a carrier, or any provider contract, or otherwise penalize any carrier, for invoking any of the carrier's rights. The bill also provides that a provider or carrier injured as a result of a violation or threatened violation of any provision

governing carrier business practices is entitled to injunctive relief against any and all violators or persons threatening violation.

The bill requires a provider contract to permit a provider a maximum of 90 days from the date a health care service is rendered to submit a claim for payment. The bill requires carriers to supply fee schedules in writing and in machine-readable electronic format and to provide the complete fee schedule applicable to the provider for each health plan in which the provider participates or is proposed to participate. The bill requires that amendments to a provider contract be presented in a manner so as to allow the provider to easily identify the specific terms being proposed for amendment and that proposed amendments be formatted to clearly identify the changes to the language of the agreement.