Health Care Cost Transparency Bill Comparisons
2014 HB 2668 (Enrolled), 2015 SB 122, and 2015 SB 172

	2014 HB 2668 (Enrolled)	2015 SB 122	2015 SB 172
Bill Title	An act concerning health care predetermination requests relating to health insurance benefits coverage.	An act concerning fees charged for services at hospital-based facilities.	An act concerning insurance; enacting the patient right to shop act.
Title of Act	Predetermination of Health Care Benefits Act	N/A	Patient Right to Shop Act
Effective Date	Effective and in force from and after July 1, 2017, and publication in the statute book	Publication in statute book	Publication in statute book
Findings Included	The bill contains a list of findings including that the people of Kansas all benefit if health plans were required to provide real-time Explanations of Benefits on request when a physician submits an electronic claim predetermination request.	No findings included in the bill.	No findings included in the bill.
Party Taking Action	The health care provider makes the predetermination request. (Sec. 1)	The hospital or health system must provide written notice of a facility fee. (Sec. 2)	The request would be made by the patient or prospective patient. (Sec. 2)

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Definitions	(Sec. 1(f)) **Health plan:** the same meaning as in KSA 40-4602 (any hospital or medical expense policy, health, hospital or medical service corporation contract, a plan provided by a municipal group-funded pool, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans). **Health care provider:** the same meaning as in KSA 40-4602 (physician, hospital or other person which is licensed, accredited or certified to perform specified health care services) and includes advance practice registered nurses and physician assistants. **Payment:** only a deductible or coinsurance payment and does not include a copayment.	(Sec. 1) **Affiliated provider:** a provider that is employed by a hospital or health care system, under a professional services agreement with a hospital or health care system that permits such hospital or health care system to bill on behalf of such provider, or a clinical faculty member of the University of Kansas Medical School, who is affiliated with a hospital or health system in a manner that permits such hospital or health system to bill on behalf of such clinical faculty member. **Campus:** the physical area immediately adjacent to a hospital's main buildings and other areas and structures not strictly contiguous to the main buildings but located within 250 yards of the main buildings; or any other area determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital campus. **Facility fee:** any fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is intended to compensate the hospital or health care system for the operational expenses of the hospital or health care system, and is separate and distinct from a professional fee.	(Sec.1) **Allowed amount:** the contractually agreed upon amount paid by a carrier to a health care entity for health care services provided to a patient covered by a carrier. **Carrier:** any insurance company, nonprofit medical and hospital service corporation, nonprofit optometric, dental or pharmacy service corporation, municipal group-funded pool, fraternal benefit society, health maintenance organization or any other entity that offers a health plan subject to Kansas law, as defined in KSA Chapter 40. **Health benefit plan:** the meaning ascribed to it in KSA 40-4602 (any hospital or medical expense policy, health, hospital or medical service corporation contract, a plan provided by a municipal group-funded pool, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans). **Health care entity:** the meaning ascribed to it in KSA 65-6731 (an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization or any other health care facility or organization). **Insured:** the meaning ascribed to it in KSA 40-4602 (a person who is covered by a health benefit plan).

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Definitions (continued)		**Health system:** a parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership, or other means; or a hospital and any entity affiliated with such hospital through ownership, governance, membership, or other means. **Hospital:** the same meaning as in KSA 65-425. **Hospital-based facility:** a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital and professional medical services are provided. **Professional fee:** any fee charged or billed by a provider for professional medical services provided in a hospital-based facility. **Provider:** an individual, entity, corporation or health care provider, whether for profit or nonprofit, whose primary purpose is to provide professional medical services or diagnostic testing.	**Participating provider:** the meaning ascribed to it in KSA 40-4602 (a provider who, under a contract with the health insurer or with its contractor or subcontractor, has agreed to provide one or more health care services to insureds with an exception of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insurer). **Provider:** the meaning ascribed to it in KSA 40-4602 (a physician, hospital, or other person which is licensed, accredited, or certified to perform specified health care services).

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Process Established	A request and information transaction process is established, termed the "health care predetermination request and response," and submitted by the health care provider to the health plan. (Sec. 1(d))	If a hospital or health system charges a facility fee utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services or diagnostic testing provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health care system would be required to provide the patient with a written notice. (Sec. 2) If a hospital or health system charges a facility fee without utilizing a CPT E/M code for outpatient services provided at a hospital-based facility located outside the hospital campus, the hospital or health care system would be required to provide the patient with a written notice. (Sec. 2)	Upon the request by a patient or prospective patient, a health care facility would have to disclose the allowed amount or charge of the admission, procedure, or service, including the amount of any facility fees required. (Sec. 2)
Requirements of Health Care Determination Request and Response	The electronic request and response must be conducted in accordance with the transactions and code sets standards promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the related Code of Federal Regulations, Title 45, parts 160 and 162 or later versions. The two transaction sets specified are the ASC X12 837 health care predetermination: professional transaction and the ASC X12 837 health care predetermination: institutional. (Sec.1(d)) Compliance with any operating rules that may be adopted with respect to this transaction or any of its successors are required, without regard to whether those operating rules are mandated by HIPAA. (Sec. 1(d))	N/A	N/A

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Required Action by Health Plan, Hospital, or Health System	Upon receipt of an electronic health predetermination request, the health plan is required to provide the health care provider the amounts of expected benefits coverage on the procedures specified in the request that is accurate at the time of the health plan's response. (Sec.1(b))	Hospital or health system must proactively provide the patient with written notice of the facility fee. (Sec. 2)	Prior to admission, procedure, or service, and upon the request by a patient or prospective patient, a health care facility would have to disclose, within two working days, the allowed amount or charge of the admission, procedure, or service, including the amount of any facility fees required. (Sec. 3)
Health Plan Bound by Request Provided	A request provided in good faith is deemed an estimate only and not binding upon the health plan with regard to the final amount of benefits actually provided by the plan.(Sec.1(b))	N/A	The information provided by the health care entity to a patient or prospective patient would be based on the information available at the time of the request. A health care entity may assist a patient or prospective patient in using a carrier's toll-free telephone number and website. (Sec. 2) The carrier would be required to notify an insured that the costs cited are estimated costs and that the actual amount the insured would be responsible to pay might vary due to unforeseen services arising from the proposed admission, procedure, or service. (Sec. 3)

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Information Required to be Provided by the Hospital, Health System, or Health Care Entity	N/A	**If a hospital or health system charges a facility fee utilizing a CPT E/M code for outpatient services or diagnostic testing provided at a hospital-based facility where a professional fee is also expected to be charged,** the written notice of a facility fee provided to the patient would include that the hospital-based facility is part of a hospital or health system that charges a facility fee that is in addition to or separate from the provider's professional fee; the amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional medical services or diagnostic testing are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed is not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee; a statement the patient's actual financial liability will depend on the professional medical services actually provided; and an explanation the patient may incur financial liability greater than he or she would incur if the professional services and diagnostic testing were not provided by a hospital based facility; and that a patient covered by a health insurance policy should contact the health insurer for additional information on the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees. (Sec. 2(a))	If the 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 would be required to disclose the estimated maximum allowed amount or charge for a proposed admission, procedure, or service, including the amount of any facility fees required. (Sec. 2) If a patient or prospective patient is covered by a carrier, a health care entity that participates in a carrier's provider network would be required to provide sufficient information regarding the proposed admission, procedure, or service to allow the patient to use the toll-free telephone number and website of such patient's carrier in order to disclose out-of-pocket costs in accordance with Section 3 of the bill. (Sec. 2)

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Information Required to be Provided by the Hospital, Health System, or Health Care Entity (continued)		**If the hospital or health system charges a facility fee without utilizing a CPT E/M code for outpatient services provided at a hospital-based facility located outside the hospital campus,** the written notice of a facility fee provided to the patient would include that the hospital-based facility is part of a hospital or health system that charges a facility fee that may be in addition to or separate from the provider's professional fee; a statement the patient's actual financial liability will depend on the professional medical services actually provided; and an explanation the patient may incur financial liability greater than he or she would incur if the hospital-based facility was not hospital-based; and that a patient covered by a health insurance policy should contact the health insurer for additional information on the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees. (Sec. 2(b))	

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Information Required to be Provided by the Health Plan or Carrier	The health care services information required to be provided in the response by the health plan is the amount the patient will be expected to pay, clearly identifying any deductible amount, coinsurance, and copayment; the amount the health care provider and institution will be paid; and whether any payments will be reduced or increased from the agreed fee schedule amounts and, if so, the health care policy that identifies why the payments will be reduced or increased. (Sec. 1 (c))	N/A.	A carrier offering a health benefit plan in Kansas would have to meet the following requirements: establish a toll-free telephone number and website that enable an insured to request and obtain from the carrier information on the average price paid to a participating provider for a proposed admission, procedure, or service in each provider area established by the carrier and to request an estimate as required in (b); within two business days of an insured's request for an estimate, a carrier would be required to provide a binding estimate for the maximum allowed amount or charge for a proposed admission, procedure, or service and the estimated amount the insured would be responsible to pay for such 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 benefit. For purposes of Section 3, "allowed amount" would mean the contractually agreed upon amount paid by the carrier to the provider for health care services provided to an insured in a carrier's health benefit plan. An insured would not be required to pay more than the disclosed amounts for the covered health care benefits that were actually provided. However, the carrier would not be prohibited from imposing cost-sharing requirements disclosed in the carrier's certificate of coverage for unforeseen health care services that arise out of the proposed admission, procedure, or service. (Sec. 3)

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Incentives to Insured	N/A	N/A	If an insured elects to receive health care services from a participating provider that costs less than the average cost for a particular admission, procedure, or service, a carrier would be required to pay the insured 50 percent of the saved cost, except that the carrier would not be required to make such a payment if the saved cost was $25 or less. (Sec. 3) If an insured elects to receive health car services from an out-of-network provider that costs less than the average cost for a particular admission, procedure, or service, a carrier shall apply the insured's share of the cost of those health care services as specified in the insured's health benefit plan toward the insured's out-of-pocket limit as if the health care services were provided by a participating provider. (Sec. 3)

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Timing, Transmission, and Form of Response or Written Notice	The response of the health plan to the predetermination request must be returned in the same form of transmission as that of the submission. (Sec. 1)	The written notice would have to be in plain language and in a form that may be reasonably understood by the patient who does not possess special knowledge regarding hospital or health system facility fee charges. (Sec. 2(c)) For non-emergency care, if the patient's appointment is scheduled to occur ten or more days after the appointment is made, the written notice would be required to be sent to the patient by first-class mail, encrypted electronic mail or a secure patient internet portal not less that three days after the appointment is made. If the appointment is scheduled to occur less than ten days after the appointment is made or if the patient arrives without an appointment, the notice would be required to be hand-delivered to the patient when the patient arrives at the hospital-based facility. (Sec. 2(d)) For emergency care, the written notice would be required to be provided to the patient as soon as practicable after the patient is stabilized in accordance with the federal Emergency Medical Treatment and Active Labor Act (42 USC § 1395dd) or is determined not to have an emergency medical condition and before the patient leaves the hospital-based facility. If the patient is unconscious, under great duress or for any other reason unable to read the notice and understand and act on such patient's rights, the notice shall be provided to the patient's representative as soon as practicable. (Sec. 2(d))	N/A
Applicability of Written Notice	N/A	Written notice of facility fees would not apply if a patient is insured by Medicare or Medicaid or is receiving services under a workers compensation plan established to provide medical services pursuant to article 5 of Chapter 44 of KSA. (Sec. 2(e))	N/A

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Display of Written Notice	N/A	A hospital-based facility would be required to prominently display written notice in locations readily accessible to and visible by patients, including patient waiting areas, stating that the hospital-based facility is part of a hospital or health system and, if the hospital-based facility charges a facility fee, the patient may incur financial liability greater than the patient would incur if the hospital-based facility was not hospital-based. (Sec. 2(f))	N/A
Public Notice	N/A	A hospital-based facility would be required to hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage, marketing materials, internet websites, and stationery. (Sec. 2(g))	N/A
Collection of Payment for Services Subject to a Predetermination Request	The Act precludes the collection of any payment prior to or as a condition of receiving the health benefit services subject to the predetermination request, unless this practice is not prohibited by the health care provider agreement with the health plan. (Sec. 1(g))	N/A	N/A
Rules and Regulations Authority	The Insurance Commissioner is required to adopt rules and regulations necessary to carry out the provisions of the Act. (Sec. 1(h))	N/A	N/A