HOUSE BILL No. 2668

AN ACT concerning health care predetermination requests relating to health insurance benefits coverage.

WHEREAS, The legislature hereby finds and declares that:

(1) Health plans have the ability today to provide a real-time explanation of benefits (EOB), enabling patients and their physicians to learn how a claim for services will be adjudicated at the point of care, including information on if the service is covered, the amount to be paid to the physician and the patient's financial responsibility for copayments, coinsurance and any remaining deductible obligation;

(2) real-time EOBs have the potential to significantly reduce health care costs by making the true cost of health care services transparent to patients and their physicians at the time treatment decisions are being made and by reducing the costs of collections which accrue when paper EOBs are not received until weeks or months after the services are provided; and

(3) real-time EOBs also have the potential to eliminate the financial uncertainty that currently plagues the health care system and would remove another layer of complexity and anxiety for patients at a time when they should be focused on their health. This is particularly important for patients for whom this financial exposure may be large, such as for the increasing number of patients with high-deductible health plans, or for those patients who purchase coverage on a health insurance exchange, for whom relatively modest changes to patient income can affect eligibility and enrollment status as they transition between medicaid, subsidized and unsubsidized qualified health plans; and

WHEREAS, The people of the state of Kansas would all benefit if health plans were required to provide real-time EOBs on request when a physician submits an electronic claim predetermination request:

Now, therefore,

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

Section 1. (a) This section shall be known as and may be cited as the predetermination of health care benefits act.

(b) (1) Health plans that receive an electronic health care predetermination request consistent with the requirements set forth in subsection (c) shall provide to the requesting healthcare provider information on 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.

(2) Any predetermination request provided under this section in good faith shall be deemed to be an estimate only and shall not be binding upon the health plan with regard to the final amount of benefits actually provided by the health plan.

(c) The amounts for the referenced services in subsection (b) shall include:

(1) The amount the patient will be expected to pay, clearly identifying any deductible amount, coinsurance and copayment;

(2) the amount the healthcare provider will be paid;

(3) the amount the institution will be paid; and

(4) whether any payments will be reduced, but not to $0, 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.

(d) This electronic request and response transaction shall be known as the health care predetermination request and response. The health care predetermination request and response shall be conducted in accordance with the transactions and code sets standards promulgated pursuant to the health insurance portability and accountability act of 1996 (HIPAA) public law 104-191, and 45 code of federal regulations, parts 160 and 162 or later versions, specifically, the ASC X12 837 health care predetermination: Professional transaction or the ASC X12 837 healthcare predetermination; institutional and any of their respective successors, without regard to whether this transaction is mandated by HIPAA. It shall also comply with any operating rules that may be adopted with respect to this transaction or any of its successors, without regard to whether these operating rules are mandated by HIPAA.

(e) The health plan's response to the health care predetermination request shall be returned using the same transmission method as that of the submission.

(f) For purposes of this section:

(1) "Health plan" shall have the same meaning as that term is defined in K.S.A. 40-4602, and amendments thereto;

(2) "healthcare provider" shall have the same meaning as the term "provider" as such term is defined in K.S.A. 40-4602, and amendments thereto. Healthcare provider shall also include:

(A) An advanced practice registered nurse as defined in K.S.A. 65-1113, and amendments thereto; and

(B) a physician assistant as defined in K.S.A. 65-28a02, and amendments thereto; and

(3) "payment" means only a deductible or coinsurance payment and does not include a copayment.

(g) This act precludes the collection of any payment prior to or as a condition of receiving the health benefit services that are the subject of a predetermination request, unless this practice is not prohibited by the provider agreement with the health plan.

(h) The commissioner of insurance shall adopt rules and regulations necessary to carry out the provisions of this section.

Sec. 2. This act shall take effect and be in force from and after July 1, 2017, and its publication in the statute book.

I hereby certify that the above BILL originated in the HOUSE, and passed that body

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HOUSE concurred in SENATE amendments _____

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Speaker of the House.

_____

Chief Clerk of the House.

Passed the SENATE as amended _____

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President of the Senate.

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Secretary of the Senate.

APPROVED _____

_____

Governor.