SESSION OF 2014

SUPPLEMENTAL NOTE ON HOUSE BILL NO. 2668

As Amended by Senate Committee on Financial Institutions and Insurance

Brief*

HB 2668, as amended, would make certain findings on behalf of the Legislature and would enact the Predetermination of Health Care Benefits Act.

Among the findings, the bill states the people of Kansas all benefit if health plans were required to provide real-time Explanation of Benefits (EOBs) on request when a physician submits an electronic claim predetermination request. The bill also states the Legislature finds and declares,

- Health plans have the ability today to provide a real-time EOB, enabling patients and their physicians to learn how a claim for services will be adjudicated at the point of care;
- 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;
- 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.

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*Supplemental notes are prepared by the Legislative Research Department and do not express legislative intent. The supplemental note and fiscal note for this bill may be accessed on the Internet at http://www.kslegislature.org

Predetermination of Health Care Benefits Act

The bill would create the Predetermination of Health Care Benefits Act and establish a request and information transaction process termed by the bill as the "health care predetermination request and response". Health plans that receive an electronic health predetermination request would be required to provide to the requesting 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. Any such request provided in good faith would be deemed to be an estimate only and would not be binding upon the health plan with regard to the final amount of benefits actually provided by the plan.

Health Care Services; Information to be Provided

The bill would specify the following information to be provided in the response by the health plan:

- 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.

Health Care Predetermination Request and Response

The bill would require this electronic request and response transaction to 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 45 Code of Federal

Regulations, parts 160 and 162 or later versions. The bill would specify two transaction sets – the ASC X12 837 health care predetermination: professional transaction and the ASC X12 837 health predetermination: institutional. The bill also would require compliance with any operating rules that may be adopted with respect to this transaction or any of its successors, without regard to whether those operating rules are mandated by HIPAA.

The response of the health plan to the predetermination request must be returned using the same form of transmission as that of the submission; this would include a real-time response for a real-time request.

Definitions; Payments and Predetermination Requests; Rules and Regulations

The bill would create definitions for the following terms:

- Health plan – the same meaning as defined 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 defined in KSA 40-4602 (physician, hospital or other person which is licensed, accredited or certified to perform specified health care services). The term also would include:
  - Advanced practice registered nurses;
  - Physician Assistants.

- Payment – the term would mean only a deductible or coinsurance payment and does not include a copayment.

The bill states the Act would preclude the collection of any payment prior to or as a condition of receiving the health benefit services subject to a predetermination request, unless this practice is not prohibited by the provider agreement with the health plan.

The bill would require the Insurance Commissioner to adopt rules and regulations necessary to carry out the provisions in the bill.

Effective Date

The bill will be effective and be in force from and after July 1, 2017, and publication in the statute book.

Background

HB 2668, as amended by the House Committee on Commerce, would have amended a provision in the Insurance Code to add any other qualified trade, merchant, retail or professional association or business league, and farmers' cooperatives to the list of associations providing health insurance coverage exempted from the jurisdiction of the Kansas Insurance Commissioner. The Senate Committee on Financial Institutions and Insurance amendments deleted those provisions and inserted provisions creating the Predetermination of Health Care Benefits Act (modified version of 2014 SB 251).

SB 251 was introduced at the request of Senator Denning. As introduced, the bill would have made certain findings on behalf of the Legislature and would have enacted the Real-Time Explanation of Health Care Benefits Act. The bill would have required health plans that receive an electronic predetermination request to provide the patient and

the physician with information on the amounts of expected benefits coverage for the specified procedure. The provided information must be accurate at the time of the response by the health plan; the information, with a few exceptions, would be considered a binding estimate. The bill, as introduced, would have been effective and be in force from and after January 1, 2015, and publication in the statute book.

Following the bill hearing in the Senate Committee, a Subcommittee was appointed to study the bill and its potential effects on health care consumers, insurers, and providers, and specific concerns addressed by conferees. The Subcommittee reported to the Committee on March 12, 2014; its recommendations included a balloon amendment for consideration. HB 2668, as amended by the Senate Committee on Financial Institutions and Insurance, incorporates these changes to the bill. The balloon amendment presented by the Subcommittee varied from the introduced version of the bill as follows:

- Modifies a requirement for the predetermination request from a real-time response that is binding on the health plan to:
    - Expand the health care professionals subject to the Act to include institutions;
    - Include an institutional transaction set; and
    - Provide for a good faith estimate.
- Updates references from physician to healthcare provider (as defined in KSA 40-4602) and include mid-level practitioners as providers;
- Limits the definition of health plan (the definition provided in KSA 40-4602);
- Delays the effective date of the Act to July 1, 2017; and
- Makes technical amendments.

The Senate Committee made further modifications to the effective date of the bill and included a definition for "payment" and a prohibition regarding the collection of payment related to a service that is the subject of a predetermination request.

No fiscal note on the modified version of SB 251 was available at the time of Senate Committee action.