Session of 2018

HOUSE BILL No. 2575

By Committee on Health and Human Services

1-30

AN ACT concerning insurance; relating to health insurers and self-insurers; health care providers; medical care facilities; commissioner of insurance; enacting the patient right to shop act; rules and regulations.

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

Section 1. As used in this act:

(a) "Allowed amount" means the contractually agreed upon amount paid by an insurance carrier to a health care entity participating in the insurance carrier's network.

(b) "Average" means mean, median or mode.

(c) "Commissioner" means the commissioner of insurance.

(d) "Comparable health care service" means any covered non-emergency health care service or bundle of services. The commissioner may limit what is considered a comparable health care service if an insurance carrier can demonstrate allowed amount variation among network providers is less than $50.

(e) "Department" means the department of insurance.

(f) "Health care entity" means a "health care provider," as that term is defined in K.S.A. 40-3401, and amendments thereto, or a "medical care facility," as that term is defined in K.S.A. 40-3401, and amendments thereto.

(g) "Insurance carrier" or "carrier" means a "health insurer," as that term is defined in K.S.A. 40-4602, and amendments thereto, or a "self-insurer," as that term is defined in K.S.A. 40-3401, and amendments thereto.

(h) "Program" means the comparable health care service incentive program established by a carrier pursuant to this act.

Sec. 2. (a) On and after January 1, 2019, an insurance carrier offering a health plan in this state shall develop and implement a program that provides incentives for insureds participating in a health plan who elect to receive a comparable health care service that is covered by the plan from a health care entity that charges less than the average allowed amount paid by that carrier to an in-network health care entity for that comparable health care service.

(1) Incentives may be calculated as a percentage of the difference in allowed amounts to the average, as a flat dollar amount, or by some other

reasonable methodology approved by the commissioner. The carrier shall provide the incentive as a cash payment to the insured or credit toward the insured's annual in-network deductible and out-of-pocket limit. Carriers may let insureds decide which method they prefer to receive the incentive.

(2) The incentive program must provide insureds with at least 50% of the insurance carrier's saved costs for each service or category of comparable health care service resulting from comparison shopping by insureds. A carrier is not required to provide a payment or credit to an insured when the carrier's saved cost is $25 or less.

(3) An insurance carrier will base the average amount on the average allowed amount paid to an in-network health care entity for the procedure or service under the insured's health plan within a reasonable timeframe not to exceed one year. A carrier may determine an alternate methodology for calculating the average allowed amount, if approved by the commissioner. A carrier shall, at minimum, inform insureds of their ability and the process to request the average allowed amount for a procedure or service, both on its website and in benefit plan material.

(4) Eligibility for an incentive payment may require an insured to demonstrate, through reasonable documentation such as a quote from the health care entity, that the insured comparison-shopped prior to receiving care from the health care entity that charges less for the comparable health care service than the average allowed amount paid by that insurance carrier. Carriers shall provide additional mechanisms for the insured to satisfy this requirement by utilizing the carrier's cost transparency website or toll-free number established under this act.

(b) An insurance carrier shall make the incentive program available as a component of all health plans offered by the carrier in this state. Annually, at enrollment or renewal, a carrier shall provide notice of the availability of the program, a description of the incentives available to an insured, and how to earn such incentives.

(c) A comparable health care service incentive payment made by a carrier in accordance with this section shall not be considered an administrative expense of the carrier for rate development or rate filing purposes.

(d) Prior to offering the program to any insured, a carrier shall file a description of the program established by the carrier pursuant to this section with the commissioner in the manner determined by the insurance department. The commissioner shall review the filing made by the carrier to determine if the insurance carrier's program complies with the requirements of this section. Filings and any supporting documentation made pursuant to this subsection are confidential until the filing has been approved or denied by the commissioner.

(e) An insurance carrier shall file with the commissioner an annual

report for the most recent calendar year stating the total number of comparable health care service incentive payments made pursuant to this section, the use of comparable health care services by category of service for which comparable health care service incentives are made, the total payments made to insureds, the average amount of incentive payments made by service for such transactions, the total savings achieved below the average allowed amount by service for such transactions, and the total number and percentage of an insurance carrier's insureds that participated in such transactions. Beginning no later than 18 months after implementation of comparable health care service incentive programs under this section, and annually by April 1 of each year thereafter, the commissioner shall submit an aggregate report for all carriers filing the information required by this subsection to the house standing committee on health and human services and the senate standing committee on public health and welfare. The commissioner may set reasonable limits on the annual reporting requirements on carriers to focus on the more popular comparable health care services.

(f) The commissioner shall adopt all rules and regulations necessary to effectuate the provisions of this section. Such rules and regulations shall be adopted by December 31, 2018.

Sec. 3. (a) A carrier shall establish an interactive mechanism on its publicly accessible website that enables an insured to request and obtain information from the carrier on the payments made by the carrier to in-network health care entities for comparable health care services, as well as quality data for those health care entities, to the extent available. The interactive mechanism shall allow an insured seeking information about the cost of a specific health care service to compare allowed amounts among in-network health care entities, estimate out-of-pocket costs applicable to such insured's health plan and the average paid to an in-network health care entity for the procedure or service under the insured's health plan within a reasonable timeframe, not to exceed one year. The out-of-pocket estimate must provide a good faith estimate of the amount the insured will be responsible to pay out-of-pocket for a proposed non-emergency procedure or service that is a medically necessary covered benefit from a carrier's in-network health care entity, including any copayment, deductible, coinsurance or other out-of-pocket amount for any covered benefit, based on the information available to the carrier at the time the request is made. A carrier may contract with a third-party vendor to satisfy the requirements of this subsection.

(b) Nothing in this section shall prohibit a carrier from imposing cost-sharing requirements disclosed in the insured's certificate of coverage for unforeseen health care services that arise out of the non-emergency procedure or service or for a procedure or service provided to an insured

that was not included in the original estimate.

(c) A carrier shall notify an insured that these are estimated costs, and that the actual amount the insured will be responsible to pay may vary due to unforeseen services that arise out of the proposed non-emergency procedure or service.

(d) The provisions of this section shall be effective upon approval by the commissioner of the first health insurance rate filing after enactment.

Sec. 4. (a) If an insured elects to receive a covered health care service from an out-of-network health care entity at a price that is the same or less than the average that such insured's insurance carrier pays for that service to in-network health care entities, then within a reasonable timeframe, not to exceed one year, the carrier shall allow the insured to obtain the service from the out-of-network health care entity at the out-of-network health care entity's price. Upon request by the insured, the carrier shall apply the payments made by the insured for that health care service toward the insured's deductible and out-of-pocket maximum as specified in the insured's health plan as if the health care services had been provided by an in-network health care entity. The carrier shall provide a downloadable or interactive online form to the insured submitting proof of payment to an out-of-network health care entity for purposes of administering this section.

(b) A carrier may base the average paid to an in-network health care entity on what that carrier pays to health care entities in the network applicable to the insured's specific health plan, or across all of its plans offered in this state. A carrier shall, at a minimum, inform insureds of their ability and the process to request the average allowed amount paid for a procedure or service, both on their website but also in benefit plan material.

(c) The commissioner shall adopt all rules and regulations necessary to effectuate the provisions of this section. Such rules and regulations shall be adopted by December 31, 2018.

Sec. 5. (a) If a patient or prospective patient is covered by insurance, then a health care entity that participates in a carrier's network shall, upon request of a patient or prospective patient, provide within two working days, based on the information available to the health care entity at the time of the request, sufficient information regarding the proposed non-emergency admission, procedure or service for the patient or prospective patient to receive a cost estimate from their insurance carrier to identify out-of-pocket costs, which could be provided through an applicable toll-free telephone number or website. A health care entity may assist a patient or prospective patient in using a carrier's toll-free number and website.

(b) If a health care entity is unable to quote a specific amount under subsection (a) or (c) 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 amount for a proposed non-emergency admission, procedure or service, including the amount for any facility fees required. A health care entity must disclose the incomplete nature of the estimate and inform the patient or prospective patient of such patient's or prospective patient's ability to obtain an updated estimate once additional information is determined.

(c) Prior to a non-emergency admission, procedure or service and upon request by a patient or prospective patient, a health care entity outside the patient's or prospective patient's insurer network shall, within two working days, disclose the price that will be charged for the non-emergency admission, procedure or service, including the amount for any facility fees required.

(d) Health care entities shall post in a visible area notification of the patient's ability, for those with individual or small group health insurance, to obtain a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American medical association sufficient to allow an insurance carrier to assist the patient in comparing out-of-pocket and contracted amounts paid for their care to different health care entities for similar services. This notification shall inform patients of their right to obtain services from a different health care entity regardless of any referral or recommendation made by a specific health care entity, and that seeing a different health care entity, either the health care entity to which the referral was made, or a different health care entity, may result in an incentive to the patient if the patient follows the steps set by the patient's insurance carrier. The notification should give an outline of the parameters of potential incentives approved in this act. The notification should also notify the patient that such patient's insurance carrier is required to provide insureds with an estimate of the out-of-pocket costs and contracted amounts paid for such patient's care to different health care entities for similar services via a toll-free telephone number and health care price transparency tool. A health care entity may provide additional information in any form to patients that informs them of carrier-specific price transparency tools or toll-free phone numbers.

(e) The commissioner shall adopt all rules and regulations necessary to effectuate the provisions of this section. Such rules and regulations shall be adopted by December 31, 2018.

Sec. 6. The Kansas state employee health care commission shall conduct an analysis no later than one year from the date of enactment of this act of the cost effectiveness of implementing an incentive-based program for the state employee health plan. Any program found to be cost effective shall be implemented as part of the next open enrollment.

Sec. 7. The provisions of sections 1 through 7, and amendments

thereto shall be known and may be cited as the patient right to shop act.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.