HOUSE BILL No. 2325

By Committee on Insurance and Pensions

2-10

AN ACT concerning insurance; relating to health insurers; healthcare providers; billing practices; prohibiting balance bills and surprise medical bills; providing for independent dispute resolution; requiring the adoption of rules and regulations; creation of provider directories; enacting the end surprise medical bills act.

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

Section 1. Sections 1 through 7, and amendments thereto, shall be known and may be cited as the end surprise medical bills act.

Sec. 2. As used in the end surprise medical bills act:

(a) "Balance bill" means a claim for payment for services provided to a covered person that is in an amount equal to the difference between the actual amount charged by a health insurer with respect to services or care described in subsection (j) and the expected in-network cost-sharing required by the covered person under the health benefit plan or coverage involved.

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

(c) "Covered person" means a member, policyholder, subscriber, covered person, beneficiary, dependent or other individual participating in a health benefit plan.

(d) "Department" means the insurance department.

(e) "Health benefit plan" means the same as provided in K.S.A. 40-4602, and amendments thereto. "Health benefit plan" includes any small employer group policy, as provided in K.S.A. 40-2209, and amendments thereto, any policy of health insurance purchased by an individual and the state employee healthcare benefits plan.

(f) "Healthcare provider" means the same as provided in K.S.A. 40-3401, and amendments thereto.

(g) "Health insurer" means the same as provided in K.S.A. 40-4602, and amendments thereto.

(h) "Independent dispute resolution process entity" or "entity" means a party that has been certified by the process described in section 5(b), and amendments thereto, and that has been selected to determine the amount that a health benefit plan or health insurer that offers health insurance in the group market shall pay an out-of-network healthcare provider.

(i) "Independent dispute resolution process" or "IDR process" means

the process described in section 5(a), and amendments thereto.
(j) "Surprise medical bill" means a balance bill that a covered person receives for services provided to the covered person where such services were:
(1) Emergency medical services provided by an out-of-network healthcare professional or at an out-of-network facility that was the closest healthcare facility to the patient's physical location at the time of the emergency medical event;
(2) healthcare services that were provided:
(A) At an in-network facility by an out-of-network healthcare professional; or
(B) in consultation with inaccurate provider directories; or
(3) (A) additional healthcare services required in the case of a covered person who initially enters a hospital through the emergency room for emergency services, and then receives nonemergency services from an out-of-network healthcare professional or at an out-of-network hospital or facility after the covered person has been stabilized, as defined in 42 U.S.C. § 300gg-19a (b)(2)(C), as determined by the treating physician.
(B) "Surprise medical bill" does not include a bill that a covered person receives for services provided to the covered person under circumstances when such covered person who is stabilized and able to travel in nonmedical transport, and the covered person, or the covered person's designee if the covered person is not able to comprehend the information to be provided or make related decisions, has:
(i) Been provided with clear, written notification that the professional or facility is an out-of-network healthcare professional or facility;
(ii) been given a cost estimate for services provided by the out-of-network healthcare professional or facility; and
(iii) assumed, in writing, full responsibility for out-of-pocket costs associated with such out-of-network care.
Sec. 3. (a) A health benefit plan, health insurer offering health insurance coverage in the group market or healthcare provider shall not engage in balance billing practices for services provided:
(1) In hospitals and ambulatory surgery centers, as those terms are defined in K.S.A. 65-425, and amendments thereto, emergency rooms and state-accredited freestanding emergency departments; and
(2) at healthcare provider offices and for related services ordered by an in-network healthcare provider and provided by an out-of-network healthcare provider or laboratory. Such services shall include, but not be limited to, laboratory and imaging services.
(b) A covered person shall only be liable for the in-network cost-sharing amount provided for in the covered person's plan or coverage, and payments made by the covered person for such cost-sharing shall count

toward the covered person's in-network deductible and out-of-pocket maximum limitation.

(c) The commissioner shall enforce the provisions of this section. The provisions of this section shall not apply to a health insurer, healthcare provider or health benefit plan that unknowingly balances bills on a covered person and reimburses such covered person within 30 calendar days of such billing.

Sec. 4. (a) (1) A health benefit plan, health insurer offering health insurance coverage in the group market or healthcare provider shall not issue a covered person a surprise medical bill.

(2) A health benefit plan, health insurer offering health insurance coverage in the group market or healthcare provider shall offer to pay the median in-network rate under the plan or coverage, less the applicable covered person's in-network cost-sharing, directly to the healthcare provider.

(b) The healthcare provider may accept payment under subsection (a)(2), or the health benefit plan or health insurer shall provide information to the healthcare provider about how the healthcare provider may initiate independent dispute resolution under section 5, and amendments thereto, with respect to such payment. The plan, issuer or provider may negotiate an alternative amount or initiate independent dispute resolution under the provisions of section 5, and amendments thereto, during the 30-calendar day period beginning on the date that the automatic payment was made under this section.

Sec. 5. (a) On or before July 1, 2022, the commissioner, in consultation with the governor, shall establish an IDR process for resolving payment disputes between health benefit plans or health insurers offering health insurance coverage in the group market and out-of-network healthcare providers involved in surprise medical bill disputes in accordance with section 4, and amendments thereto.

(b) A party wishing to participate in the IDR process under subsection (a) shall request certification from the commissioner. The commissioner, in consultation with the governor, shall determine eligibility of applicant parties, taking into consideration whether the party is independent and unaffiliated with the insurance industry and with healthcare providers and is free of conflicts of interest, in accordance with any relevant criteria relating to conflicts of interest set by the commissioner through rules and regulations.

(c) Under the process established under subsection (a), the parties in the IDR process shall jointly agree upon an entity. In the event that the parties cannot agree, an entity shall be selected at random by the department of labor.

(d) (1) The IDR process may occur in disputes involving one or more

current procedural terminology, CPT codes.

(2) Group health plans, health benefit plans, health insurers, healthcare providers and healthcare facilities may batch claims if they involve:

(A) Identical parties to the disputes;

(B) claims with the same or related CPT codes relevant to a particular procedure; and

(C) claims that occur within 30 calendar days of each other.

(e) (1) An entity that receives a request for resolution under this section, no later than 30 days after receiving such request, shall determine the amount the health benefit plan or health insurer offering health insurance coverage in the group market is required to pay the out-of-network health care provider. Such amount shall be:

(A) The amount determined by the parties through a settlement, pursuant to paragraph (2); or

(B) an amount determined reasonable by the entity, in accordance with paragraph (3).

(2) If the entity determines, based on the amounts indicated in the request under this section, that a settlement between the health benefit plan or health insurer offering health insurance coverage in the group market and the out-of-network health care provider is likely, the entity may direct the parties to attempt, for a period not to exceed 10 calendar days, a good faith negotiation for a settlement. Such 10-day period shall accrue towards the 30-day period required under paragraph (1).

(3) (A) In the absence of a settlement under paragraph (2), the health benefit plan or health insurer offering health insurance coverage in the group market and the out-of-network healthcare provider shall each submit to the entity their final offers. Such entity shall determine which of the two amounts is more reasonable based on the factors described in subparagraph (D).

(B) The amount that the entity determines to be the more reasonable amount under subparagraph (A) shall be the final decision of the entity as to the amount the health benefit plan or health insurer offering health insurance coverage in the group market shall be required to pay to the out-of-network healthcare provider.

(C) A final determination under subparagraph (B) may include the resolution of disputes for multiple items or services if such determination is in regard to items or services that are eligible for independent dispute resolution due to the batching of claims.

(D) In determining which final offer to select as the more reasonable amount under subparagraph (A), the entity shall consider relevant factors including, but not limited to:

(i) Commercially reasonable rates for comparable services or items

offered in the same geographic area; and

(ii) other factors that may be submitted at the discretion of either party, or at the entity's request.

(E) A final determination made by an entity under subparagraph (B) shall:

(i) Be binding; and

(ii) not be subject to judicial review, except in cases comparable to those described in 9 U.S.C. § 10(a), as determined by the commissioner in consultation with the governor, and cases in which information submitted by one party was determined to be fraudulent.

(4) In conducting an IDR process under this subsection, an entity shall comply with all applicable state and federal privacy laws.

(5) The reasonable amount determined by an entity under this subsection with respect to any claim shall not be confidential, except that information submitted to the entity shall be kept confidential. Entities may consider past decisions awarded by other entities during the IDR process.

(6) The non-prevailing party shall be responsible for paying all fees charged by the entity. If the parties reach a settlement prior to the completion of the IDR process, the costs of the IDR process shall be divided equally between the parties.

(7) Health benefit plans and health insurers offering health insurance coverage in the group market shall pay directly to the out-of-network healthcare provider the amount determined by the entity within 30 days of the final determination. A plan or insurer that fails to comply with this paragraph shall be subject to a civil monetary penalty set by the commissioner through rules and regulations.

Sec. 6. (a) If a patient schedules an appointment with an out-of-network healthcare provider, the healthcare provider shall make a reasonable effort to notify the patient within 48 hours of scheduling the appointment that the provider is not a member of the patient's health benefit plan's provider network.

(b) Within 48 hours, healthcare providers shall notify health insurers that offer health insurance in the group or market of any personnel change or other factor that could impact the accuracy of insurer provider directories.

(c) (1) A health insurer that offers health insurance in the group market shall post on its website a current and accurate electronic provider directory for each of its network plans including the information described in subsection (g). Such online provider directory shall be easily accessible in a standardized, downloadable, searchable and machine-readable format.

(2) In making the provider directory available online, the insurer shall ensure that the general public is able to view all of the current providers for a network plan through a clearly identifiable link or tab without

creating or accessing an account or entering a policy or contract number.

(3) The insurer shall update each network plan on the online provider directory not less than once every 30 calendar days.

(d) For each network plan, an insurer shall include in plain language:

(1) A description of the criteria the insurer has used to build its provider network;

(2) if applicable, a description of the criteria the insurer has used to tier providers;

(3) if applicable, how the insurer designates the different provider tiers, such as by name, symbols or grouping, in the network and for each provider in the network and in which tier each provider is placed to facilitate a covered person's or a prospective covered person's ability to identify the provider tier; and

(4) if applicable, a notice that authorization or referral may be required to access some providers.

(e) The insurer shall make clear for both its electronic and print directories the provider directory that applies to each network plan by identifying the specific name of the network plan as marketed and issued in the state.

(f) Provider directories, whether in electronic or print format, shall be accessible to individuals with disabilities and individuals with limited English proficiency as defined in 45 C.F.R. § 92.201 and 45 C.F.R. § 155.205(c).

(g) The insurer shall make available through an online provider directory, for each network plan, the following information:

(1) For healthcare professionals:

(A) Name;

(B) gender;

(C) contact information;

(D) participating office location or locations;

(E) specialty, if applicable;

(F) board certifications, if applicable;

(G) medical group affiliations, if applicable;

(H) participating facility affiliations, if applicable;

(I) languages spoken other than English by the healthcare professional or clinical staff, if applicable;

(J) tier; and

(K) whether they are accepting new patients;

(2) For hospitals:

(A) Hospital name;

(B) hospital type;

(C) participating hospital location;

(D) hospital accreditation status; and

(E) contact information; and
(3) For facilities other than hospitals:
(A) Facility name;
(B) facility type;
(C) types of services performed;
(D) participating facility location or locations; and
(E) contact information.

(h) The insurer shall include in its online and print directories a clearly identifiable telephone number and a dedicated email address or a link to a dedicated webpage that covered persons or the general public may use to report to the insurer inaccurate information listed in the provider directory. Whenever an insurer receives such a report, it shall promptly investigate such report. Not later than 30 calendar days following receipt of such report, the insurer shall either verify the accuracy of the information or update the information, as applicable.

(i) An insurer shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the insurer's provider directory and shall, no later than January 1, 2022, review and update the entire provider directory for each network plan offered. Thereafter, the insurer shall annually audit a reasonable sample size of its provider directories for accuracy, retain documentation of such audit, make such documentation available to the commissioner upon request and based on the results of such audit, verify the accuracy of the information or update the information in the provider directories.

(j) If a covered person reasonably relied upon materially inaccurate information contained in an insurer's provider directory, the commissioner may require the insurer to reimburse the covered person for all covered healthcare services provided to the covered person in an amount that the covered person would have paid, had the services been delivered by an in-network provider under the insurer's network plan. The commissioner shall take into consideration that insurers rely on healthcare providers to report changes to the information required under subsection (g) prior to requiring any reimbursement to a covered person. Before requiring reimbursement, the commissioner shall conclude that the services received by the insurer were covered services under the covered person's network plan. The fact that the services were rendered or delivered by a noncontracting or out-of-network provider shall not be used as a basis to deny reimbursement to the covered person.

Sec. 7. The commissioner of insurance shall adopt all rules and regulations as may be necessary to implement and administer the provisions of this act. The commissioner shall adopt such rules and regulations on or before July 1, 2022.

Sec. 8. This act shall take effect and be in force from and after its

1 publication in the statute book.