Session of 2020

SENATE BILL No. 282

By Committee on Federal and State Affairs

1-21

AN ACT concerning health and healthcare; relating to providers; healthcare providers and insurance providers; charge estimates and disclosures; enacting the patient's right-to-know act.

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

Section 1. (a) This section shall be known and may be cited as the patient's right-to-know act.

(b) As used in this section:

(1) "Ambulatory surgical center" means the same as defined in 42 C.F.R. § 416.2.

(2) "Average paid rate" means the average amount that a healthcare provider currently accepts as payment in full for a healthcare service, diagnostic test or procedure after any discount applicable to certain patients is applied.

(3) "Charged rate" means the average, median or actual amount that is currently charged by a healthcare provider to a patient for a healthcare service, diagnostic test or procedure.

(4) "Clinic" means a place, other than a residence, that is used primarily for the provision of nursing, medical, podiatric, dental, chiropractic or optometric care or treatment.

(5) "Cost-sharing requirements" means copayments, deductibles, coinsurance percentages and any other cost-sharing mechanisms that apply under a health benefit plan.

(6) "Course of treatment" means, as part of a healthcare service, the management and care, including related therapy and rehabilitation, of a patient over time for the purpose of combating disease or disorder or temporarily or permanently relieving symptoms.

(7) "Health benefit plan" includes accident and sickness insurance offered by any insurer in the state of Kansas and any self-insured accident and sickness insurance offered by any political subdivision of the state.

(8) "Healthcare provider" means any person licensed by the state board of healing arts or the board of examiners in optometry to practice a profession.

(9) "Healthcare service, diagnostic test or procedure" includes physical therapy, speech therapy, occupational therapy, chiropractic treatment or mental therapy, but does not include a prescription drug.

(10) "Insured" means a person covered under a health benefit plan.

(11) "Insured's agent" means: The parent, guardian or legal custodian of an insured who is under 18 years of age; the spouse of an insured; an agent of an insured under a valid power of attorney for healthcare decisions; a guardian of an insured; or any person legally authorized by an insured to act as the insured's agent.

(12) "Insurer" means an insurer authorized by the commissioner of insurance to offer accident and sickness insurance in the state of Kansas or a political subdivision of the state offering self-insured accident and sickness insurance.

(13) "Mental therapy" includes services and treatment for mental illness, developmental disability, alcohol or drug abuse or drug dependence.

(14) "Minimum cost" means $500 or a higher amount adjusted for inflation as specified by the department of health and environment in rules and regulations.

(15) "Out-of-network" means any treatment received from a healthcare provider that is not a member of the patient's health benefit plan's preferred network.

(16) "Patient's agent" means: The parent, guardian or legal custodian of a patient who is under 18 years of age; the spouse of a patient; an agent of a patient under a valid power of attorney for healthcare decisions; a guardian of a patient; or any person legally authorized by a patient to act as the patient's agent.

(c) (1) If a patient is recommended to, referred to or is under the care of a healthcare provider for a healthcare service, diagnostic test, procedure or course of treatment for which the charge exceeds the minimum cost and the patient, or the patient's agent, requests an estimate of the charge for the service, the healthcare provider shall provide the patient, or the patient's agent, with such estimate.

(2) (A) Except as provided in subparagraph (B), an estimate of a charge shall be provided at the time of scheduling the healthcare service, diagnostic test, procedure or course of treatment or within 10 business days of the request, whichever is later, and shall include the following information:

(i) For an inpatient surgical procedure and course of treatment, the estimate shall include: The reasonably anticipated services of healthcare providers who will likely provide healthcare services during and after the procedure and during any related course of treatment; and the reasonably anticipated total charge for hospitalization, the daily charge for hospitalization and the number of days of the hospital stay;

(ii) for an outpatient surgical procedure and course of treatment, the estimate shall include the reasonably anticipated total charge;

(iii) for a nonsurgical hospital procedure and course of treatment, the estimate shall include the reasonably anticipated services of healthcare providers who will likely provide healthcare services during and after the procedure and during any related course of treatment; and

(iv) for physical therapy, speech therapy, occupational therapy, chiropractic treatment or mental therapy, the estimate shall include: A proposed treatment plan that describes the number and frequency of visits in a course of treatment and the anticipated charges for the course of treatment; and objective quality outcomes data that is related to the health outcomes of the proposed course of treatment, if the healthcare provider has made such data public. If a course of treatment is anticipated to exceed six months in duration and if the patient, or the patient's agent, requests, then the healthcare provider shall provide an estimate of the charge and proposed treatment plan for each anticipated six-month period.

(B) In lieu of the requirements imposed by subparagraph (A), a healthcare provider may provide to the patient, or the patient's agent, an estimate of the charge that is a single fixed-price estimate of the total cost of the healthcare service, diagnostic test, procedure or course of treatment.

(C) An estimate of a charge provided under this subsection shall:

(i) Represent the good-faith effort of the healthcare provider to provide accurate information to the patient, or the patient's agent;

(ii) inform the patient of the patient's responsibilities in complying with any medical requirements associated with any healthcare service, diagnostic test, procedure or course of treatment proposed and the potential cost variances due to factors that cannot reasonably be anticipated;

(iii) indicate how the health status of the patient may contribute to any charge variance that may reasonably be anticipated;

(iv) include any discounts or financial incentives that the healthcare provider is willing to offer to the patient;

(v) include a description of the healthcare service, diagnostic test, procedure or course of treatment and any appropriate medical codes that would enable the patient, or the patient's agent, to obtain applicable coverage payment information from the patient's insurer under subsection (d);

(vi) include the identify of the healthcare provider and the applicable facility, if any, with which the healthcare provider is associated;

(vii) be issued electronically, if requested by the patient, or the patient's agent;

(viii) not constitute a binding or implied contract between the parties or a guarantee that the amounts estimated will be charged; and

(ix) contain language that encourages the patient to review the estimate carefully and to contact the patient's insurer for specific coverage

information.

(d) (1) Except as prohibited by the federal health insurance portability and accountability act, and any federal rules and regulations adopted thereunder, for any health benefit plan that is delivered, issued for delivery, amended or renewed on or after July 1, 2022, an insurer shall provide the following information upon request by an insured, or the insured's agent:

(A) A description of the coverage, including benefits and cost-sharing requirements, under the insured's health benefit plan;

(B) a description of pre-certification or other requirements, if any, that the insured must complete before any care is approved by the insurer;

(C) based on the information relating to an estimate of a charge that was provided to the insured, or the insured's agent, under subsection (c), a summary of the insured's coverage with respect to a specific healthcare service, diagnostic test, procedure or course of treatment, including:

(i) The estimated total and type of out-of-pocket costs that the insured may incur, including deductibles, copayments, coinsurance and items and other charges that are not covered by the insurer;

(ii) an estimate of the amount that the insurer paid to a provider for the specific healthcare service, diagnostic test, procedure or course of treatment, provided in a manner that protects the insurer's proprietary pricing but is a reasonably close estimate of the actual amount or rate paid;

(iii) any limits on what amount the insurer will pay if the healthcare service, diagnostic test, procedure or course of treatment is provided by an out-of-network provider. If the insured provides to the insurer the applicable medical codes for the service provided or proposed to be provided by a provider that is not participating, then the insurer shall inform the insured if the cost of the service exceeds the allowable charge under the insurer's guidelines for payment for the service under the insured's health benefit plan;

(iv) any discounts or financial incentives that the insurer is willing to offer to the insured, including incentives for the insured to obtain care from a different provider;

(v) a statement that the information in the summary is based on the information relating to the estimate of the charge that was provided to the insured, or the insured's agent, under subsection (c); and

(vi) a statement that the information in the summary represents an estimate and is not a legally binding contract or guarantee of the amounts provided in the summary.

(2) An insurer may provide the information required by this subsection to the insured in writing, orally or electronically at the insured's request.

Sec. 2. This act shall take effect and be in force from and after July 1, 2022, and its publication in the statute book.