Session of 2015

SENATE BILL No. 172

By Committee on Public Health and Welfare

2-9

AN ACT concerning insurance; enacting the patient right to shop act.

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

Section 1. (a) Sections 1 through 3, and amendments thereto, shall be known and may be cited as the patient right to shop act.

(b) As used in this act:

(1) "Allowed amount" means the contractually agreed upon amount paid by a carrier to a health care entity for health care services provided to a patient covered by a carrier.

(2) "Carrier" means any insurance company, nonprofit medical and hospital service corporation, nonprofit optometric, dental or pharmacy service corporation, municipal group-funded pool, fraternal benefit society, health maintenance organization or any other entity that offers a health plan subject to the laws of the state of Kansas, as such terms are defined in chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

(3) "Health benefit plan" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto.

(4) "Health care entity" shall have the meaning ascribed to it in K.S.A. 65-6731, and amendments thereto.

(5) "Insured" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto.

(6) "Participating provider" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto.

(7) "Provider" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto.

Sec. 2. (a) (1) Prior to an admission, procedure or service and upon request by a patient or prospective patient, a health care entity shall, within two working days, disclose the allowed amount or charge of the admission, procedure or service, including the amount of any facility fees required.

(2) If a health care entity is unable to quote a specific amount in advance due to the health care entity's inability to predict the specific treatment or diagnostic code, the health care entity shall disclose the estimated maximum allowed amount or charge for a proposed admission, procedure or service, including the amount of any facility fees required.

(b) If a patient or prospective patient is covered by a carrier, a health care entity that participates in a carrier's provider network shall provide sufficient information regarding the proposed admission, procedure or service to enable such patient to utilize the toll-free telephone number and website of such patient's carrier in order to disclose out-of-pocket costs in accordance with section 3, and amendments thereto. The information provided by a health care entity to a patient or prospective patient shall be based on the information available at the time of the request. A health care entity may assist patient or prospective patient in using a carrier's toll-free telephone number and website.

Sec. 3. A carrier offering a health benefit plan in this state shall comply with the following requirements:

(a) A carrier shall establish a toll-free telephone number and website that enables an insured to request and obtain from the carrier information on the average price paid to a participating provider for a proposed admission, procedure or service in each provider network area established by the carrier and to request an estimate pursuant to subsection (b).

(b) (1) Within two business days of an insured's request, a carrier shall provide a binding estimate for the maximum allowed amount or charge for a proposed admission, procedure or service and the estimated amount the insured will be responsible to pay for such proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the carrier at the time the request is made. The estimate shall include any facility fee, copayment, deductible, coinsurance or other out-of-pocket amount for any covered health care benefits.

(2) An insured may not be required to pay more than the disclosed amounts for the covered health care benefits that were actually provided. However, this paragraph does not 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 proposed admission, procedure or service.

(3) 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 arising from the proposed admission, procedure or service.

(c) (1) If an insured elects to receive health care services from a participating provider that cost less than the average cost for a particular admission, procedure or service, a carrier shall pay to an insured 50% of the saved cost except that a carrier shall not be required to make such payment if the saved cost is $25 or less.

(2) If an insured elects to receive health care services from an out-of-network provider that costs less than the average cost for a particular

admission, procedure or service, a carrier shall apply the insured's share of the cost of those health care services as specified in the insured's health benefit plan toward the insured's out-of-pocket limit as if the health care services were provided by a participating provider.

(d) For purposes of this section, "allowed amount" means the contractually agreed upon amount paid by a carrier to a provider for health care services provided to an insured in a carrier's health benefit plan.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.