Kansas Hospital ASSOCIATION

TO: Senate Financial Institutions and Insurance Committee

FROM: Tish Hollingsworth
Vice President of Reimbursement

DATE: January 29, 2020

RE: Testimony on Senate Bill 282

The Kansas Hospital Association appreciates the opportunity to comment on Senate Bill 282, which is referred to as "The Patient's Right to Know Act".

The subject of health care pricing has been an issue of policy discussion on both the State and Federal level for many years. Throughout these discussions, our members have been firm in their belief that as we move towards a more consumer-driven health care marketplace that transparency of all health care data will be a key component for not only the consumers, but also employers and policy makers.

As you are probably aware, health care reimbursement is a very complex and heavily regulated system with thousands and thousands of pages of rules and guidelines directed by governmental as well as private payers. For the Medicare program, which typically is the highest volume of payer mix in our community hospitals, there are many fee schedules and payment systems for the various types of medical services provided in the hospital, including inpatient and outpatient services, end-stage renal disease, home health, hospice, inpatient psych, and inpatient rehab to name a few. Because the Medicare program requires providers to **CHARGE** all patients the same, the Medicare regulations and payment systems tend to be the basis for establishing and setting billing practices. It is important to also understand that community hospitals **CHARGE** all patients in the same manner, however, each payer may **REIMBURSE** the hospital differently based on negotiated rates within a managed care contract or because of a governmental fee schedule (such as Medicare or KanCare/Medicaid). **Section 1 (b)(3) of SB 282 defines "charged rate" as 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. As noted in this paragraph, hospitals charge all patients the same. It is the reimbursement that the hospital may receive that varies from patient to patient, depending upon fee schedules, negotiated rates, and the patient's individual coverage.**

When a patient enters any health care setting, there are always many things running through their mind: What is going to happen? How long will it take? Will I be ok? And, they are probably also thinking: What is this going to cost me? Unfortunately, there are a variety of circumstances that can leave patients with high unanticipated out-of-pocket costs, such as: unforeseen medical complications, insurers controlling costs by relying on narrow networks, out-of-date provider directories that do not accurately reflect provider status with insurers' contracts, and the rising costs of prescription drugs. Furthermore, the increasing use of high-deductible health plans as well as the emergence of health benefit policies that are not ACA (Affordable Care Act) compliant, create gaps in coverage resulting in higher expenses for patients, further exacerbating the problem. **Section 1(b)(7) defines "health benefit plan". However, certain health benefit plans that are not regulated by the Insurance Commissioner, such as Christian Health Ministries and the**

Kansas Farm Bureau health benefit policy, do not appear to be covered by this definition. Further, Section 1(d)(1) requires the insurer to provide information to the patient on cost-sharing, pre-certification requirements, and coverage for out-of-network providers. A true patient cost estimate requires information from the healthcare provider on charges as well information from the insurer on provider reimbursement and patient out-of-pocket costs.

Hospitals and health systems are deeply concerned about the impact not only to the patient, but also to the hospital's ability to collect on services rendered. Even before the Centers for Medicare & Medicaid Services, the Federal Agency that oversees the Medicare and Medicaid programs, imposed transparency requirements for hospitals, our hospitals had processes in place to help patients with the resources needed to understand what their anticipated out-of-pocket costs may be. Hospitals communicate to patients in many ways including posting information on their website, providing information in written brochures and in verbal communications with the patient. However, payment for health care services has evolved into an incredibly complex system that is costly to administer for both providers and payers of care. Depending upon the size of the hospital or health system, a central business office may deal with anywhere from 20 to 100 different payers, in addition to Medicare and Medicaid. Each payer's contracting requirements and basis for payments is different – sometimes slightly, sometimes significantly – but, it's up to the hospital to adapt to each one. **Section 1(b)(2) of SB 282 refers to "average paid rate", which would be extremely burdensome if not virtually impossible for a hospital to provide based on the number of health plans and the multitude of employer-specific benefit plans within each health plan**.

Due to the urgent nature of health care and the degree of highly specialized knowledge required for many hospital services, it is unrealistic to expect healthcare consumers to immediately comprehend and make informed decisions about complex medical issues using detailed information about price and quality before they even obtain medical services. It is also important to note that the course of treatment of patients with the same condition varies based on the patient's existing comorbidities. Section 1(c)(1) requires, if requested by the patient or their agent, the health care provider must provide an estimate for the healthcare service, diagnostic test, procedure or course of treatment. This section further requires the anticipated total charge for inpatient surgical procedures, the daily charge for hospitalization and number of days of the hospital stay, and well as similar information for nonsurgical hospital procedures. **As previously noted, the course of treatment of patients varies based on the patient's comorbidities prior to treatment as well as any unforeseen complications, specifically for surgical procedures. In addition, hospitals are most commonly paid on a Diagnosis-Related Grouping (DRG) for inpatient services, which is a payment allowance determined by the payer regardless of the charges incurred, making the requirement of daily charges or total charges not relative to the patient's cost sharing amount. Providing estimates for the "course of treatment" would require collecting estimates from an unknown list of post-acute providers without the benefit of knowing the patient's medical outcome, making it unrealistic to provide.**

In 2014, KHA supported the passage of the Predetermination of Health Care Benefits Act (2014: House Bill 2668) which was effective in 2017. This health care pricing transparency legislation set the groundwork to provide patients, upon their request, the necessary tools to obtain information regarding the potential out-of-pocket expenses for health care services. Senate Bill 282 appears to add more administrative burden to health care providers, without increasing the patient's knowledge of the expected cost of their health care services.

On behalf of the members of the Kansas Hospital Association, we respectfully ask the Senate Financial Institutions and Insurance Committee to oppose the passage of Senate Bill 282. Thank you for your consideration of our comments.