House _____ **Amendment NO.**____

Offered By

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AMEND House Committee Substitute for Senate Committee Substitute for Senate Bill No. 836, Page 1, Section A, Line 4, by inserting after all of said section and line the following:

"191.875. 1. This section shall be known as the "Health Care Cost Reduction and Transparency Act".

2. As used in this section, the following terms shall mean:

(1) "Ambulatory surgical center", as such term is defined under section 197.200;

(2) "Department", the department of health and senior services;

(3) "Estimate of cost", an estimate based on the information entered and assumptions about typical utilization and costs for health care services. Such estimates of cost shall encompass only those services within the direct control of the health care provider and shall include the following:

(a) The amount that will be charged to a patient for the health services if all charges are paid in full without a public or private third party paying for any portion of the charges;

(b) The average negotiated settlement on the amount that will be charged to a patient required to be provided in paragraph (a) of this subdivision;

(c) The amount of any MO HealthNet reimbursement for the health care services, including claims and pro rata supplemental payments, if known; and

(d) The amount of any Medicare reimbursement for the medical services, if known;

(4) "Health care provider", any ambulatory surgical center, assistant physician, chiropractor, clinical psychologist, dentist, hospital, imaging center, long-term care facility, nurse anesthetist, optometrist, pharmacist, physical therapist, physician, physician assistant, podiatrist, registered nurse, or other licensed health care facility or professional providing health care services in this state. "Health care provider" shall also include any provider located in a Kansas border county, as defined under section 135.1670, who participates in the MO HealthNet program;

(5) "Hospital", as such term is defined under section 197.020;

(6) "Imaging center", any facility at which diagnostic imaging services are provided including, but not limited to, magnetic resonance imaging;

(7) "Medical treatment plan", a patient-specific plan of medical treatment for a particular illness, injury, or condition determined by such patient's health care provider, which includes the applicable current procedural terminology code or codes;

(8) "Public or private third party", a state government, the federal government, employer, health carrier as such term is defined under section 376.1350, third-party administrator, or managed care organization.

3. Beginning July 1, 2017, upon written request by a patient, which shall include a medical treatment plan from the patient's health care provider, for an estimate of cost of a particular health care service or procedure, imaging procedure, or surgery procedure, a health care provider shall

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provide, in writing, the estimate of cost to the patient electronically, by mail, or in person within three business days after receiving the written request. Providing a patient a specific link to such estimates of cost and making such estimates of cost publicly available or posting such estimates of cost on a website of the health care provider shall constitute compliance with the provisions of this subsection.

4. Health care providers shall include with any estimate of cost the following: "Your estimated cost is based on the information entered and assumptions about typical utilization and costs. The actual amount billed to you may be different from the estimate of costs provided to you. Many factors affect the actual bill you will receive, and this estimate of costs does not account for all of them. Additionally, the estimate of costs is not a guarantee of insurance coverage. You will be billed at the health care provider's charge for any service provided to you that is not a covered benefit under your plan. Please check with your insurance company to receive an estimate of the amount you will owe under your plan or if you need help understanding your benefits for the service chosen.".

5. Each health care provider shall also make available the percentage or amount of any discounts for cash payment of any charges incurred through the health care provider's website or by making it available at the health care provider's location.

6. Beginning July 1, 2017, hospitals shall make available to the public, in the manner and format determined by the department, the amount that would be charged without discounts for each of the one hundred most prevalent diagnosis-related groups as defined by the Medicare program, Title XVIII of the Social Security Act. The diagnosis-related groups shall be described in layperson's language suitable for use by reasonably informed patients. Disclosure of data under this subsection shall constitute compliance with subsection 3 of this section regarding any diagnosis-related group for which disclosure is required under this subsection.

7. Beginning July 1, 2017, each hospital, ambulatory surgical center, and imaging center shall make available to the public, in the manner and format determined by the department, the amount that would be charged without discounts for the twenty most common outpatient surgical procedures or the twenty most common imaging procedures, as appropriate, performed in such settings. Disclosure of data under this subsection shall constitute compliance with subsection 3 of this section regarding any surgical or imaging procedure for which disclosure is required under this subsection.

8. It shall be a condition of participation in the MO HealthNet program for a health care provider located in a Kansas border county, as defined under section 135.1670, to comply with the provisions of this section.

9. No health care provider shall be required to report the information required by this section if the reporting of such information reasonably could lead to the identification of the person or persons receiving health care services or procedures in violation of the federal Health Insurance Portability and Accountability Act of 1996 or other federal law. This section shall not apply to emergency departments, which shall comply with requirements of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. Section 1395dd.

10. The department shall promulgate rules to implement the provisions of this section. The rules relating to subsections 6 and 7 of this section shall include all of the following:

(1) The one hundred most frequently reported diagnosis-related groups for inpatients for which hospitals will provide the data required under subsection 6 of this section; and

(2) The twenty most common outpatient surgical procedures and the twenty most common imaging procedures, by volume, performed in a hospital, ambulatory surgical center, or imaging center as required under subsection 7 of this section.

Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall be invalid and void."; and

Further amend said bill, Page 19, Section 336.020, Line 9, by inserting after all of said section and line the following:

"376.1475. 1. This section shall be known and may be cited as the "Predetermination of Health Care Benefits Act".

2. For the purposes of this section, the following terms shall mean:

(1) "Administrative simplification provision", transaction and code standards promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and 45 CFR 160 and 162;

(2) "Director", the director of the department of insurance, financial institutions and professional registration;

(3) "Health benefit plan" and "health care provider", the same meanings as those terms are defined in section 376.1350;

(4) "Health care clearinghouse", the same meaning as the term is defined in 45 CFR 160.103;

(5) "Payment", a deductible or coinsurance payment and shall not include a co-payment;

(6) "Standard electronic transactions", electronic claim and remittance advice transactions created by the Accredited Standards Committee (ASC) X12 in the format of ASC X12 837I, ASC X12 837P, or ASC X12 835, or any of their respective successors.

3. Health benefit plans that receive an electronic health care predetermination request from a health care provider consistent with the requirements set forth in subsection 6 of this section shall provide the requesting health care provider with information on the amount of expected benefits coverage on the procedures specified in the request that is accurate at the time of the health benefit plan's response.

4. Any predetermination response provided by a health benefit plan under this section in good faith shall be deemed to be an estimate only and shall not be binding upon the health benefit plan with regard to the final amount of benefits actually provided by the health benefit plan.

5. The amounts for the referenced services under subsection 3 of this section shall include:

(1) The amount the patient will be expected to pay, clearly identifying any deductible amount, coinsurance, and co-payment;

(2) The amount the health care provider will be paid;

(3) The amount the institution will be paid; and

(4) Whether any payments will be reduced, but not to zero dollars, or increased from the agreed fee schedule amounts, and if so, the health care policy that identifies why the payments will be reduced or increased.

6. The health care predetermination request and predetermination response shall be conducted in accordance with administrative simplification provisions using the currently applicable standard electronic transactions, without regard to whether the transaction is mandated by HIPAA. It shall also comply with any rules promulgated by the director, without regard to whether such rules are mandated by HIPAA. To the extent HIPAA-mandated electronic claim and remittance

transactions are modified to include predetermination, the provisions of this section shall not apply to health benefit plans which provide this information under HIPAA.

7. The health benefit plan's predetermination response to the health care predetermination request shall be returned using the same transmission method as that of the request. This shall include a real time response for a real time request.

8. A health care clearinghouse that contracts with a health care provider shall be required to conduct a transaction as described in subsections 5, 6, and 7 of this section if requested by the health care provider.

9. Nothing in this act precludes the collection of payment prior to receiving health benefit services once a health benefit plan has fulfilled any predetermination request.

10. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months or less duration, or any other supplemental policy.

11. The director shall adopt rules and regulations necessary to carry out the provisions of this section.

12. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall be invalid and void.

376.2020. 1. For purposes of this section, the following terms shall mean:

(1) "Contractual payment amount" or "payment amount", shall mean the total amount a health care provider is to be paid for providing a given health care service pursuant to a contract with a health carrier, and includes both the portions to be paid by the patient and by the health carrier. It is commonly referred to as the allowable amount;

(2) "Enrollee", shall have the same meaning ascribed to it in section 376.1350;

(3) "Health care provider", shall have the same meaning ascribed to it in section 376.1350;

(4) "Health care service", shall have the same meaning ascribed to it in section 376.1350;

(5) "Health carrier", shall have the same meaning ascribed to it in section 376.1350.

2. No provision in a contract in existence or entered into, amended, or renewed on or after August 28, 2016, between a health carrier and a health care provider shall be enforceable if such contractual provision prohibits, conditions, or in any way restricts any party to such contract from disclosing to an enrollee, or such person's parent or legal guardian, the contractual payment amount for a health care service if such payment amount is less than the health care provider's usual charge for the health care service, and if such contractual provision prevents the determination of the potential out-of-pocket cost for the health care service by the enrollee, parent, or legal guardian.";

and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.