

House _____ Amendment NO. _____

Offered By _____

1 AMEND House Committee Substitute for Senate Committee Substitute for Senate Bill No. 973,
2 Page 1, In the Title, Lines 2-3, by deleting the words "dispensing maintenance medication" and
3 inserting in lieu thereof the words "health care"; and
4

5 Further amend said bill and page, Section A, Line 2, by inserting after all of said section and line
6 the following:
7

8 "197.170. 1. This section shall be known and may be cited as the "Health Care Cost
9 Reduction and Transparency Act".

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

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

12 (2) "Direct payment", as such term is defined under section 1.330;

13 (3) "Health care provider", the same meaning as such term is defined under section
14 376.1350. "Health care provider" shall also include any provider located in a Kansas border county,
15 as defined under section 135.1670, who participates in the MO HealthNet program;

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

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

19 (6) "Medical treatment plan", a patient-specific plan of medical treatment for a particular
20 illness, injury, or condition determined by such patient's physician, which includes the applicable
21 current procedural terminology (CPT) code or codes.

22 3. Beginning July 1, 2018, ambulatory surgical centers and imaging centers shall make
23 available to the public, in a manner that is easily understood, an estimate of the most current direct
24 payment price information for the twenty-five most common surgical procedures or the twenty most
25 common imaging procedures, as appropriate, performed in ambulatory surgical centers or imaging
26 centers. Disclosure of data under this subsection shall constitute compliance with subsection 5 of
27 this section regarding any surgical or imaging procedure for which disclosure is required under this
28 subsection.

29 4. Not later than July 1, 2017, hospitals shall make available to the public, in a manner that
30 is easily understood, the amount that would be charged without discounts for each the one hundred
31 most prevalent diagnosis-related groups as defined by the Medicare program, Title XVIII of the
32 Social Security Act. The diagnosis-related groups shall be described in layman's language suitable
33 for use by reasonably informed patients. Disclosure of data under this subsection shall constitute
34 compliance with subsection 5 of this section regarding any diagnosis-related group for which
35 disclosure is required under this subsection.

36 5. Upon written request by a patient, which shall include a medical treatment plan from the
Standing Action Taken _____ Date _____

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1 patient's physician, for the direct payment cost of a particular health care service or procedure,
 2 imaging procedure, or surgery procedure, a health care provider, hospital, ambulatory surgical
 3 center, or imaging center shall provide an estimate of the direct payment price information required
 4 by this section to the patient in writing either electronically, by mail, or in person, within three
 5 business days after receiving the written request. Providing a patient a specific link to such
 6 estimated prices and making such estimated prices publicly available or posting such estimated
 7 prices on a website of the health care provider, hospital, ambulatory surgical center, or imaging
 8 center shall constitute compliance with the provisions of this subsection.

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

15 7. It shall be a condition of participation in the MO HealthNet program for a health care
 16 provider located in a Kansas border county, as defined under section 135.1670, to comply with the
 17 provisions of this section."; and
 18

19 Further amend said bill and page, Section 338.202, Line 13, by inserting after all of said section and
 20 line the following:
 21

22 "376.1475. 1. This section shall be known and may be cited as the "Predetermination of
 23 Health Care Benefits Act".

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

25 (1) "Administrative simplification provision", transaction and code standards promulgated
 26 under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-
 27 191, and 45 CFR 160 and 162;

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

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

32 (4) "Health care clearinghouse", the same meaning as the term is defined in 45 CFR
 33 160.103;

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

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

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

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

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

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

1 (2) The amount the health care provider will be paid;
2 (3) The amount the institution will be paid; and
3 (4) Whether any payments will be reduced, but not to zero dollars, or increased from the
4 agreed fee schedule amounts, and if so, the health care policy that identifies why the payments will
5 be reduced or increased.

6 6. The health care predetermination request and predetermination response shall be
7 conducted in accordance with administrative simplification provisions using the currently applicable
8 standard electronic transactions, without regard to whether the transaction is mandated by HIPAA.
9 It shall also comply with any rules promulgated by the director, without regard to whether such
10 rules are mandated by HIPAA. To the extent HIPAA-mandated electronic claim and remittance
11 transactions are modified to include predetermination, the provisions of this section shall not apply
12 to health benefit plans which provide this information under HIPAA.

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

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

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

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

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

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

34 Section B. Section 376.1475 of Section A of this act shall become effective July 1, 2018.";
35 and

36
37 Further amend said bill by amending the title, enacting clause, and intersectional references
38 accordingly.