SENATE

KENTUCKY GENERAL ASSEMBLY AMENDMENT FORM

2020 REGULAR SESSION

Amend printed copy of **SB 150/SCS 1**

On pages 16 to 19, delete Section 3 of this Act in its entirety, and insert in lieu thereof:

"➔SECTION 3. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Balance bill" or "balance billing" refers to a provider billing an insured for the remaining balance of the amount a provider charges for a service less the following:

1. The amount an insurer reimburses; and

2. Any applicable cost-sharing the insured is required to pay;

(b) "Covered health care services" means:

1. Health care services that are covered under an insured's health benefit plan; or

2. Noncovered health care services that would otherwise be covered under the insured's health benefit plan if the services were provided by a participating provider;

(c) "Emergency health care services" means health care services that are provided in a health facility after the sudden onset of an emergency medical condition;

(d) "Insured" means a person covered under a health benefit plan;

Amendment No. SFA 1 Rep. Sen. Ralph Alvarado

Committee Amendment Signed:

Floor Amendment LRC Drafter:

Adopted: Date:

Rejected: Doc. ID: XXXX

(e) "Median in-network rate" means the median of all contracted commercial rates paid by the health benefit plan or delegated entity for the same or similar health care services in the same geographic region; and

(f) "Unanticipated out-of-network care":

1. Means covered health care services received by an insured in a health facility from a nonparticipating provider when the insured did not have the ability to direct that the services be provided by a participating provider, including out-of-network emergency health care services; and

2. Does not include nonemergency health care services, if the insured voluntarily selects in writing a nonparticipating provider prior to the provision of services.

(2) A nonparticipating provider shall send a bill for unanticipated out-of-network care to the insured's insurer. Within the timeframes required under KRS 304.17A-700 to 304.17A-730, the insurer shall:

(a) Reimburse the nonparticipating provider at the greater of the following, less any cost-sharing owed by the insured:

1. The insurer's median in-network rate for the current year; or

2. The insurer's median in-network rate for the year 2018; and

(b) Send a notice to the nonparticipating provider of any cost-sharing owed under the insured's health benefit plan for the unanticipated out-of-network care. The amount of cost-sharing owed shall:

1. Not exceed the amount of cost-sharing that would have been owed if the services were provided by a participating provider; and

2. Be calculated based on the reimbursement amount determined under this section.

(3) (a) For purposes of subsection (2)(a) of this section, if the insurer has insufficient information in any year, as specified by the commissioner in accordance with paragraph (b) of this subsection, to calculate the median in-network rate for an item or service furnished in a geographic region by a type of provider, the median in-network rate shall be the median in-network rate recognized by all health plans offered in the same line of business for the item or service furnished in a geographic region using a database or other source information determined appropriate by the commissioner.

(b) The commissioner shall promulgate administrative regulations to determine when an insurer has insufficient information to calculate a median in-network rate, which shall include but not be limited to a finding that the insurer's provider network fails to include, as participating providers, the majority of providers located in the geographic region which are of the same provider type as the provider which provided the item or service.

(4) A nonparticipating provider who has been reimbursed by an insurer under subsection (2) of this section:

(a) Shall not balance bill an insured; and

(b) May bill an insured for any applicable cost-sharing.

(5) (a) Any cost-sharing that the insured pays under this section shall be attributable to any annual deductibles and out-of-pocket maximums required under the terms of the insured's health benefit plan.

(b) The entire amount paid by the insured to the nonparticipating provider shall be attributable to any annual deductible and out-of-pocket maximums required under the terms of the insured's health benefit plan when an insurer does not make a reimbursement under this section because the cost-sharing owed for the

unanticipated out-of-network care is equal to or more than the reimbursement amount determined under this section.

(6) A nonparticipating provider shall accept the reimbursement made under subsection (2) of this section, plus any applicable cost-sharing owed by an insured, as the full and final payment for the unanticipated out-of-network care, except as provided in Section 4 of this Act.

(7) An appropriate regulatory agency or board that licenses, certifies, or otherwise authorizes a provider to provide health care services in this state may take any disciplinary action that the board or agency is authorized to take against regulated providers under the agency's or board's authorizing statutes against a provider that violates this section."; and

On pages 19 to 23, delete Section 4 of this Act in its entirety and insert in lieu thereof:

"➔SECTION 4. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Usual and customary rate" means the eightieth percentile of all charges for a particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographic region as reported under Section 2 of this Act; and

(b) "Unanticipated out-of-network care" has the same meaning as in Section 3 of this Act.

(2) The commissioner shall:

(a) Establish and administer:

1. An independent dispute resolution program in accordance with this section; and

2. An application process for qualifying reviewers for the independent dispute resolution program. To be eligible as a qualified reviewer, an individual shall:

a. Demonstrate knowledge of and experience in applicable principles of contract and insurance law and the healthcare industry generally; and

b. Not have a conflict of interest that would adversely impact the individual's independence or impartiality, including but not limited to current or recent ownership or employment of the individual, or a close family member, in any insurer issuing health benefit plans, administrator of health benefit plans, or health care provider; and

(b) Maintain:

1. A portal on the department's Web site through which a request to dispute the reimbursement made under Section 3 of this Act may be made;

2. A list of qualified reviewers for the independent dispute resolution program; and

3. Records of the information reported under subsection (11) of this section.

(3) (a) A nonparticipating provider may elect to dispute the reimbursement provided under Section 3 of this Act if, within thirty (30) days of the insurer's reimbursement under Section 3 of this Act, the nonparticipating provider submits a dispute request through the portal on the department's Web site.

(b) A nonparticipating provider may submit up to ten (10) charges in one (1) dispute request when:

1. The reimbursements for the charges are received by the nonparticipating provider within the same thirty (30) day period; and

2. The charges are for a similar medical service or procedure.

(4) If a nonparticipating provider submits a dispute request in accordance with subsection (3) of this section:

(a) Both the nonparticipating provider and the insurer shall participate in and comply with the requirements of this section; and

(b) On the date the dispute request is submitted, the nonparticipating provider shall provide written notice, which shall include transmissions via e-mail or facsimile, of the request, in a form and manner prescribed by the commissioner, to:

1. The commissioner; and

2. The insurer.

(5) (a) If the cumulative amount of charges for the unanticipated out-of-network care in a dispute request is less than six hundred seventy-five dollars ($675), the parties shall engage in an informal settlement conference in accordance with subsection (6) of this section.

(b) 1. If the cumulative amount of charges for the unanticipated out-of-network care in a dispute request is six hundred seventy-five dollars ($675) or more, the parties shall engage in an informal settlement conference in accordance with subsection (6) of this section. If a settlement is not reached, the parties shall submit information to a reviewer in accordance with subsection (8)(a) of this section.

2. The parties may select a reviewer by agreement. If a selection is made under this paragraph, the nonparticipating provider shall notify the commissioner of the selection within twenty (20) days of the dispute request submitted under subsection (3) of this section.

3. If the commissioner has not received notification that the parties have selected a reviewer within twenty (20) days, the commissioner shall, within

ten (10) days, select a qualified reviewer from his or her list of qualified reviewers established under subsection (2) of this section.

4. The reviewer's fees shall be split evenly and paid by the insurer and the nonparticipating provider.

(6) (a) Within thirty (30) days from the date of the dispute request submitted under subsection (3) of this section, the parties shall participate in an informal settlement conference to attempt to settle the dispute. A reviewer shall not participate in the informal settlement conference.

(b) The nonparticipating provider shall notify the commissioner whether the parties reached a settlement within five (5) days of completion of the conference.

(7) The parties shall not be entitled to engage in discovery in connection with the independent dispute resolution program.

(8) The reviewer shall:

(a) Set a date for the submission of all information to be considered by the reviewer;

(b) Except as provided in subsection (11) of this section, hold in strict confidence all information provided by a party and all communications of the reviewer with the parties; and

(c) Not later than sixty (60) days after the date of the dispute request submitted under subsection (3) of this section, provide the parties with a written decision that:

1. Determines the reasonable amount owed to the nonparticipating provider for the unanticipated out-of-network care; and

2. Selects, as the amount awarded under this section, the amount determined under subparagraph 1. of this paragraph.

(9) The reviewer's determination under subsection (8)(c) of this section:

(a) Shall take into account:

1. Whether there is a gross disparity between the charges billed by the nonparticipating provider and:

a. Reimbursements paid to the nonparticipating provider for the same health care service rendered by the provider to other insureds for which the provider is a nonparticipating provider; and

b. Reimbursements paid by the insurer to reimburse similarly qualified nonparticipating providers for the same health care services in the same region;

2. The level of training, education, and experience of the nonparticipating provider;

3. The nonparticipating provider's historical data, for charges billed and reimbursements received, for comparable health care services with regard to other insureds;

4. The circumstances and complexity of an insured's particular case, including the time and place of the provision of health care services;

5. An individual insured's medical conditions, co-morbidities, and other medical characteristics;

6. The current and historical data for the usual and customary rate of the health care service provided, which shall be:

a. Except as provided in subdivision b. of this subparagraph, the lesser of the following:

i. The usual and customary rate for the health care service provided for the current year; or

ii.. The usual and customary rate for the health care service provided for the year 2021; or

b. If there is not data available for the year 2021, the usual and customary rate for the health care service provided for the current year; and

7. The history of network contracting between the parties; and

(b) May take into account any other information relevant to the value of the health care service provided.

(10) Except as provided in subsection (13) of this section, any deadline under this section may be extended by agreement of the parties.

(11) A reviewer shall provide a report to the commissioner, in a form and manner prescribed by the commissioner, of each amount awarded under this section.

(12) Not later than thirty (30) days after the date of the reviewer's decision, an insurer shall pay the nonparticipating provider any amount necessary to satisfy the amount awarded by the reviewer under this section.

(13) Within forty-five (45) days of a reviewer's decision under this section, a party may file a civil action to determine the amount owed, if any, by the insurer to the nonparticipating provider for unanticipated out-of-network care under Section 3 of this Act.

(14) Information submitted by the parties to the reviewer shall not be subject to public disclosure under KRS 61.800 to 61.878.

(15) Nothing in this section shall be construed to limit the admissibility, in any civil action, of the reviewer's determination or the information provided during the independent dispute resolution process."; and

On page 24, after line 12 insert:

"***(4) Sections 3 and 4 of this Act shall not apply to a provider for unanticipated out of network care, as defined in Section 3 of this Act, provided to an insured of any health plan or health plan sponsor not otherwise required to comply with Sections 3 and 4 of this Act unless such plan or sponsor provides written notice under subsection (3) of this section***

of its election to have Sections 3 and 4 of this Act apply to the plan."; and

On page 24, lines 13 to 27, delete Section 6 of this Act in its entirety and insert in lieu thereof:

"➔SECTION 6. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) An insurer shall provide written notice of any claim made for unanticipated out-of-network care, as defined in Section 3 of this Act, in an explanation of benefits, provided to an insured and the nonparticipating provider, in a format prescribed by the commissioner, which shall include:

(a) A statement of the balance billing prohibition in Section 3 of this Act; and

(b) For an explanation of benefits provided to a nonparticipating provider, information, as prescribed by the commissioner, relating to the provider's rights under Section 4 of this Act.

(2) The insurer shall provide the explanation of benefits, with the notices required under this section, not later than the date an insurer makes a reimbursement under Section 3 of this Act.".