AN ACT relating to health care price transparency.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

As used in Sections 1 to 7 of this Act, unless context requires otherwise:

(1) "Ancillary service" means a facility item or service that a facility customarily provides as part of a shoppable service;

(2) "Cabinet" means the Cabinet for Health and Family Services;

(3) "Chargemaster" means the list of all facility items or services maintained by a facility for which the facility has established a charge;

(4) "De-identified maximum negotiated charge" means the highest charge that a facility has negotiated with all third-party payors for a facility item or service;

(5) "De-identified minimum negotiated charge" means the lowest charge that a facility has negotiated with all third-party payors for a facility item or service;

(6) "Discounted cash price" means the charge that applies to an individual who pays cash, or a cash equivalent, for a facility item or service;

(7) "Facility" means a hospital licensed under this chapter;

(8) "Facility items or services" means all items and services, including individual items and services and service packages, that may be provided by a facility to a patient in connection with an inpatient admission or an outpatient department visit, as applicable, for which the facility has established a standard charge, including:

(a) Supplies and procedures;

(b) Room and board;

(c) Use of the facility and other areas, the charges for which are generally referred to as facility fees;

(d) Services of physicians and nonphysician practitioners employed by the

facility, the charges for which are generally referred to as professional charges; and

(e) Any other item or service for which a facility has established a standard charge;

(9) "Gross charge" means the charge for a facility item or service that is reflected on a facility's chargemaster, absent any discounts;

(10) "Machine-readable format" means a digital representation of information in a file that can be imported or read into a computer system for further processing, and includes .XML, .JSON, and .CSV formats;

(11) "Payor-specific negotiated charge" means the charge that a facility has negotiated with a third-party payor for a facility item or service;

(12) "Service package" means an aggregation of individual facility items or services into a single service with a single charge;

(13) "Shoppable service" means a service that may be scheduled by a health care consumer in advance;

(14) "Standard charge" means the regular rate established by the facility for a facility item or service provided to a specific group of paying patients, and includes all of the following as defined in this section:

(a) The gross charge;

(b) The payor-specific negotiated charge;

(c) The de-identified minimum negotiated charge;

(d) The de-identified maximum negotiated charge; and

(e) The discounted cash price; and

(15) "Third-party payor" means an entity or government program that provides coverage for health care services that are furnished to the entity's or program's insureds or beneficiaries.

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO

READ AS FOLLOWS:

Notwithstanding any other law to the contrary, a facility shall make public a:

(1) Digital file in a machine-readable format that contains a list of all standard charges, expressed in dollar amounts, for all facility items or services as described in Section 3 of this Act; and

(2) Consumer-friendly list of standard charges, expressed in dollar amounts, for a limited set of shoppable services as provided in Section 4 of this Act.

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

(1) A facility shall maintain a chargemaster of all standard charges, expressed in dollar amounts, for all facility items or services in accordance with this section.

(2) The standard charges contained in the chargemaster shall reflect the standard charges, expressed in dollar amounts, applicable to that location of the facility, regardless of whether the facility operates in more than one (1) location or operates under the same license as another facility.

(3) The chargemaster shall include the following items, as applicable:

(a) A description of each facility item or service provided by the facility;

(b) The following standard charges, expressed in dollar amounts, for each individual facility item or service when provided in either an inpatient setting or an outpatient department setting, as applicable:

1. The gross charge;

2. The de-identified minimum negotiated charge;

3. The de-identified maximum negotiated charge;

4. The discounted cash price; and

5. The payor-specific negotiated charge, listed by the name of the third-party payor and plan associated with the charge and displayed in a manner that clearly associates the charge with each third-party payor

and plan; and

(c) Any code used by the facility for purposes of accounting or billing for the facility item or service, including the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis Related Group (DRG) code, National Drug Code (NDC), or other common identifier.

(4) The information contained in the chargemaster shall be published in a single digital file that is in a machine-readable format.

(5) The chargemaster required under subsection (1) of this section shall be displayed in a prominent location on the home page of the facility's publicly accessible website or accessible by selecting a dedicated link that is prominently displayed on the home page of the facility's publicly accessible website. If the facility operates multiple locations and maintains a single website, the chargemaster required under subsection (1) of this section shall be posted for each location the facility operates in a manner that clearly associates the chargemaster with the applicable location of the facility.

(6) The chargemaster required under subsection (1) of this section shall:

(a) Be available:

1. Free of charge;

2. Without having to register or establish a user account or password;

3. Without having to submit personal identifying information; and

4. Without having to overcome any other impediment, including entering a code to access the list;

(b) Be accessible to a common commercial operator of an internet search engine to the extent necessary for the search engine to index the list and display the list as a result in response to a search query of a user of the search engine;

(c) Be formatted in a manner prescribed by the cabinet;

(d) Be digitally searchable; and

(e) Use the naming convention specified by the Centers for Medicare and Medicaid Services on its website.

(7) The facility shall update the chargemaster at least one (1) time each year. The facility shall clearly indicate the date on which the list was most recently updated, either on the chargemaster or in a manner that is clearly associated with the chargemaster.

(8) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A to establish a template for each facility to use to create the chargemaster. The cabinet shall:

(a) Consider any applicable federal guidelines for formatting similar chargemasters required by federal law or rule and ensure that the design of the template enables health care researchers to compare the charges contained in the chargemasters maintained by each facility; and

(b) Design the template to be substantially similar to the wide-format .CSV template used by the Centers for Medicare and Medicaid Services for purposes similar to those of this section.

➔SECTION 4. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

(1) (a) A facility shall maintain and make publicly available a chargemaster of the standard charges described by subsection (3)(b) of Section 3 of this Act for each of at least three hundred (300) shoppable services provided by the facility. The facility may select the shoppable services to be included in the chargemaster, except that the chargemaster shall include:

1. The services specified as shoppable services by the Centers for Medicare and Medicaid Services; or

2. If the facility does not provide all the shoppable services described by subparagraph 1. of this paragraph, as many of those shoppable services as the facility does provide.

(b) If a facility does not provide three hundred (300) shoppable services, the facility shall maintain a chargemaster of the total number of shoppable services that the facility provides in a manner that otherwise complies with the requirements of paragraph (a) of this subsection.

(2) In selecting a shoppable service for purposes of inclusion in the chargemaster required under subsection (1) of this section, a facility shall:

(a) Consider how frequently the facility provides the service and the facility's billing rate for that service; and

(b) Prioritize the selection of services that are among the services most frequently provided by the facility.

(3) The chargemaster required under subsection (1) of this section:

(a) Shall include:

1. A plain-language description of each shoppable service included;

2. The payor-specific negotiated charge, expressed in a dollar amount, that applies to each shoppable service included and any ancillary service, listed by the name of the third-party payor and plan associated with the charge and displayed in a manner that clearly associates the charge with the third-party payor and plan;

3. The discounted cash price, expressed in a dollar amount, that applies to each shoppable service included and any ancillary service or, if the facility does not offer a discounted cash price for one (1) or more of the shoppable or ancillary services, the gross charge for the shoppable service or ancillary service, as applicable;

4. The de-identified minimum negotiated charge, expressed in a dollar

amount, that applies to each shoppable service included and any ancillary service;

5. The de-identified maximum negotiated charge, expressed in a dollar amount, that applies to each shoppable service included and any ancillary service; and

6. Any code used by the facility for purposes of accounting or billing for each shoppable service included and any ancillary service, including the CPT, HCPCS, DRG, or NDC code, or other common identifier;

(b) If applicable, shall:

1. State each location at which the facility provides the shoppable service and whether the standard charges included apply at that location to the provision of that shoppable service in an inpatient setting, an outpatient department setting, or both of those settings, as applicable; and

2. Indicate if one (1) or more of the shoppable services specified by the Centers for Medicare and Medicaid Services is not provided by the facility; and

(c) As applicable, shall be:

1. Displayed in the manner prescribed in subsection (5) of Section 3 of this Act, for the chargemaster required under that section;

2. Available:

a. Free of charge;

b. Without having to register or establish a user account or password;

c. Without having to submit personal identifying information; and

d. Without having to overcome any other impediment, including entering a code to access the chargemaster;

3. Searchable by service description, billing code, and payor;

4. Updated in the manner prescribed in Section 3 of this Act for the chargemaster required under that section;

5. Accessible to a common commercial operator of an internet search engine to the extent necessary for the search engine to index the list and display the chargemaster as a result in response to a search query of a user of the search engine; and

6. Formatted in a manner that is consistent with the format prescribed by the cabinet in Section 3 of this Act.

➔SECTION 5. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

(1) The cabinet shall monitor each facility's compliance with the requirements of Sections 2, 3, and 4 of this Act using any of the following methods:

(a) Evaluating complaints made by persons to the cabinet regarding noncompliance;

(b) Reviewing any analysis prepared regarding noncompliance; and

(c) Auditing the websites of facilities for compliance with this section.

(2) If the cabinet determines that a facility is not in compliance with a provision of Section 2, 3, or 4 of this Act the cabinet shall take the following actions:

(a) Provide a written notice to the facility that clearly explains the manner in which the facility is not in compliance;

(b) Request a corrective action plan from the facility if the facility has materially violated a provision of Section 2, 3, or 4 of this Act; and

(c) Impose an administrative penalty, as determined under Section 7 of this Act, on the facility and publicize the penalty on the cabinet's internet website if the facility fails to:

1. Respond to the cabinet's request to submit a corrective action plan; or

2. Comply with the requirements of a corrective action plan submitted to the cabinet.

(3) Beginning no later than ninety (90) days after the effective date of this Act, the cabinet shall create and maintain a publicly available list on its website of hospitals that have been found to have violated Section 2, 3, or 4 of this Act, or that have been issued an administrative penalty or sent a warning notice, a request for a corrective action plan, or any other written communication from the cabinet related to the requirements of Section 2, 3, or 4 of this Act. Such penalties, notices, and communications shall be subject to public disclosure under 5 U.S.C. sec. 552, notwithstanding any exemptions or exclusions to the contrary, in full without redaction. This list shall be updated at least every thirty (30) days thereafter.

(4) Notwithstanding any provision of law to the contrary, in considering an application for renewal of a hospital's license or certification, the cabinet shall consider whether the hospital is or has been in compliance with Section 2, 3, or 4 of this Act.

➔SECTION 6. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

(1) A facility materially violates Section 2, 3, or 4 of this Act if the facility fails to:

(a) Comply with the requirements; or

(b) Publicize the facility's standard charges in the form and manner required.

(2) If the cabinet determines that a facility has materially violated Section 2, 3, or 4 of this Act, the cabinet shall issue a notice of material violation to the facility and request that the facility submit a corrective action plan. The notice shall indicate the form and manner by which the corrective action plan shall be submitted to the cabinet, and clearly state the date by which the facility shall submit the plan.

(3) A facility that receives a notice under subsection (2) of this section shall:

(a) Submit a corrective action plan in the form and manner and by the specified date prescribed by the notice of violation; and

(b) As soon as practicable after submission of a corrective action plan to the cabinet, comply with the plan.

(4) A corrective action plan submitted to the cabinet shall:

(a) Describe in detail the corrective action the facility will take to address any violation identified by the cabinet in the notice provided under subsection (2) of this section; and

(b) Provide a date by which the facility will complete the corrective action.

(5) A corrective action plan shall be subject to review and approval by the cabinet. After the cabinet reviews and approves a facility's corrective action plan, the cabinet shall monitor and evaluate the facility's compliance with the plan.

(6) A facility is considered to have failed to respond to the cabinet's request to submit a corrective action plan if the facility fails to submit a corrective action plan:

(a) In the form and manner specified in the notice provided; or

(b) By the date specified in the notice provided under subsection (2) of this section.

(7) A facility is considered to have failed to comply with a corrective action plan if the facility fails to address a violation within the specified period of time contained in the plan.

➔SECTION 7. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

(1) The cabinet shall impose an administrative penalty on a facility if the facility fails to:

(a) Respond to the cabinet's request to submit a corrective action plan; or

(b) Comply with the requirements of a corrective action plan submitted to the cabinet.

(2) The cabinet shall impose an administrative penalty on a facility for a violation of each requirement of Sections 1 to 7 of this Act. The cabinet shall set the penalty in an amount sufficient to ensure compliance by a facility with the provisions of Sections 2, 3, and 4 of this Act subject to the limitations in subsection (3) of this section.

(3) The penalty imposed by the cabinet shall not be lower than:

(a) In the case of a hospital with a bed count of thirty (30) or fewer, six hundred dollars ($600) for each day in which the hospital fails to comply with the requirements;

(b) In the case of a hospital with a bed count that is greater than thirty (30) and equal to or fewer than five hundred fifty (550), twenty dollars ($20) per bed for each day in which the hospital fails to comply with the requirements; or

(c) In the case of a hospital with a bed count that is greater than five hundred fifty (550), eleven thousand dollars ($11,000) for each day in which the hospital fails to comply with the requirements.

(4) Each day a violation continues shall be considered a separate violation.

(5) In determining the amount of the penalty, the cabinet shall consider:

(a) Previous violations by the facility's operator;

(b) The seriousness of the violation;

(c) The demonstrated good faith of the facility's operator; and

(d) Any other matters the cabinet finds appropriate.

➔SECTION 8. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Emergency medical condition" means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would

reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part; or

2. With respect to a pregnant woman who is having contractions:

a. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child;

(b) "Health care provider":

1. Means any person who:

a. Provides health care services to a patient; and

b. Is required to be licensed, certified, or otherwise authorized under the laws of this state to provide the health care services; and

2. Includes a health facility as defined in KRS 216B.015;

(c) "Health care service":

1. Means any health care-related treatment, procedure, screening, test, or other service provided by a health care provider; and

2. Includes the provision of prescription drugs, as defined in KRS 315.010, and home medical equipment, as defined in KRS 309.402;

(d) "Third-party payor" means an entity or government program that provides coverage for health care services that are furnished to the entity's or

program's insureds or beneficiaries; and

(e) "Written pricing sheet" means a written statement from a health care provider to a patient, or if applicable, the patient's authorized representative, that:

1. States:

a. The following for any health care service that the health care provider will or may provide to the patient:

i. A description of each health care service; and

ii. The total amount that the health care provider will seek in payment for each health care service; and

b. Of the total amount referenced in subdivision a.ii. of this subparagraph:

i. The portion of the amount that the health care provider will seek in payment from, or anticipates will be paid by, a third-party payor; and

ii. The portion of the amount that the health care provider is seeking, or anticipates seeking, from the patient; and

2. Includes the following, under the conspicuous caption "ACKNOWLEDGMENT OF PATIENT" after the statements referenced in subparagraph 1. of this paragraph:

"I, [enter name of patient and if applicable, indicate the name of any authorized representative acting on the patient's behalf], hereby acknowledge by my signature on the line below that I: 1. Have received a copy of this written pricing sheet; and 2. To the extent consistent with state and federal law, and any hold harmless agreements or other payor-specific contractual rights to which I am a beneficiary, accept the charges for each health care service set forth in

this written pricing sheet.

(Signature line)

(Printed name of patient and if applicable, the printed name of any authorized representative acting on the patient's behalf)

(Date)".

(2) Except as provided in subsection (6) of this section, a health care provider shall, to the extent permitted under federal law, do the following prior to providing any health care service to a patient:

(a) Provide the patient, or if applicable, the patient's authorized representative, a written pricing sheet; and

(b) Obtain the patient's signature, or if applicable, the signature of the patient's authorized representative acting on the patient's behalf, on the written pricing sheet provided to the patient or the patient's authorized representative.

(3) (a) For any health care service that was provided to a patient in violation of subsection (2) of this section, a health care provider shall, to the extent permitted under federal law:

1. Not bill or otherwise receive reimbursement directly from the patient or the patient's authorized representative for the health care service; and

2. Have the right to bill, or otherwise seek reimbursement from, the patient's third-party payor for the health care service.

(b) This subsection shall not be construed to require a third-party payor to pay or reimburse a health care provider more than what the third-party payor would otherwise be legally responsible to pay or reimburse.

(4) Nothing in this section waives:

(a) A third-party payor's legal responsibility to pay or reimburse a health care

provider for a health care service that was provided to a patient, regardless of whether that health care service was provided in violation of subsection (2) this section; or

(b) A patient's rights:

1. Under any state or federal law that regulates the maximum amount that a health care provider is entitled to bill or receive for a health care service; or

2. As a beneficiary under a hold harmless agreement or other contract with a third-party payor.

(5) (a) To the extent permitted under federal law, a third-party payor shall not, by contract or otherwise, deny or reduce payment or reimbursement to a health care provider for any health care service that is provided to a patient solely because the health care service was provided to the patient in violation of subsection (2) of this section.

(b) Any contract provision that violates this subsection shall be void and unenforceable.

(6) This section shall not apply to a health care service that is provided to screen, treat, or stabilize, or facilitate the screening, treatment, or stabilization of, an emergency medical condition.

(7) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A to establish a template for the written pricing sheet for use by health care providers and any other requirements it deems necessary for implementing this section.

➔Section 9. If the Cabinet for Health and Family Services or the Department for Medicaid Services determines that a state plan amendment, waiver, or any other form of authorization or approval from any federal agency to implement Section 1, 2, 3, 4, 5, 6, 7, or 8 of this Act is necessary to prevent the loss of federal funds or to comply with federal

law, the cabinet or department:

(1) Shall, within 90 days after the effective date of this section, request the necessary federal authorization or approval to implement Section 1, 2, 3, 4, 5, 6, 7, or 8 of this Act; and

(2) May only delay implementation of the provisions of Section 1, 2, 3, 4, 5, 6, 7, or 8 of this Act for which federal authorization or approval was deemed necessary until the federal authorization or approval is granted.

➔Section 10. Sections 1 to 9 of this Act shall constitute the specific authorization required under KRS 205.5372(1).