FIRST REGULAR SESSION

SENATE BILL NO. 445

91ST GENERAL ASSEMBLY

INTRODUCED BY SENATOR SINGLETON.

Read 1st time February 8, 2001, and 1,000 copies ordered printed.

TERRY L. SPIELER, Secretary.

1844S.01I

AN ACT

To repeal section 376.383, RSMo 2000, relating to health insurance carriers, and to enact in lieu thereof two new sections relating to the same subject.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Section 376.383, RSMo 2000, is repealed and two new sections enacted in lieu thereof, to be known as sections 376.383 and 376.386, to read as follows:

376.383. 1. To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section shall apply to any health **[**insurer**]** **carrier** as defined in section **[**376.806, any nonprofit health service plan and any health maintenance organization**]** **376.1350**.

2. Within forty-five days after receipt of a claim for reimbursement **[**from a person entitled to reimbursement**]** **for a health care service provided in this state as defined in section 376.1350**, a health **[**insurer, nonprofit health service plan or health maintenance organization**]** **carrier** shall pay the claim in accordance with this section or send a notice of receipt and status of the claim that states:

(1) That the **[**insurer, nonprofit health service plan or health maintenance organization**]** **health carrier** refuses to reimburse all or part of the claim and the reason for the refusal; **[**or**]**

(2) **Until April 1, 2002,** that additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information **that** is necessary**; or**

(3) On or after April 1, 2002, that additional information is necessary to determine if all or part of the claim will be reimbursed and a complete description of all specific additional information that is necessary to process the entire claim.

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

3. If **[**an insurer, nonprofit health service plan or health maintenance organization**] a health carrier** fails to comply with subsection 2 of this section, the **[**insurer, nonprofit health service plan or health maintenance organization**] health carrier** shall pay interest on the amount of the claim that remains unpaid forty-five days after the claim is filed at the monthly rate of one percent. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest. **A health carrier may combine interest payments and make payment once the aggregated amount reaches five dollars.**

4. Within ten days after the day on which all additional information is received by **[**an insurer, nonprofit health service plan or health maintenance organization**] a health carrier**, it shall pay the claim in accordance with this section or send a written notice that:

(1) States refusal to reimburse the claim or any part of the claim; and

(2) Specifies each reason for denial.

[An insurer, nonprofit health service plan or health maintenance organization**] A health carrier** that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the monthly rate of one percent.

5. A provider**, as defined in section 376.1350,** who is paid interest **[**under**] pursuant to** this section shall pay the proportionate amount of **[**said**] such** interest to the enrollee or insured to the extent and for the time period that the enrollee or insured had paid for the services and for which reimbursement was due to the insured or enrollee.

6. **[**This section shall become effective April 1, 1999.**] In addition to other remedies provided by law, a person who has filed a claim for reimbursement for a health care service, as defined in section 376.1350, may file a civil action against the health carrier for any violation of this section; provided that such person may not file a civil action until the tenth day following the receipt by the health carrier of a certified letter notifying the health carrier of such person's intention to file a civil action pursuant to this section. Such notice must included the information previously submitted on the claim for reimbursement. No civil action may be filed on any claim and interest paid within the ten-day grace period. If the court finds that a violation of this section has occurred, the court shall award to a prevailing plaintiff a penalty of fifty dollars per day beginning ten days following the date that interest pursuant to this section first becomes due, in addition to the claimed reimbursement and interest.**

376.386. 1. For purposes of this section, "health care provider" or "provider" means a health care professional or facility, and "health carrier" means the same as such term is defined in section 376.1350. Any health carrier shall:

(1) Permit providers to file confirmation numbers of certified services and claims in the same manner or format;

(2) Permit providers to file claims for reimbursement for a period of up to one year following the provision of a health care service;

(3) Effective January 1, 2003, accept claims for reimbursement from health care providers that are filed electronically. Effective January 1, 2003, all claims for reimbursement filed with health carriers by health care providers that are submitted electronically shall be filed in a form and format specified by the department of insurance. The department of insurance shall promulgate rules specifying the form and format governing such electronic claims submission consistent with federal administrative simplifications standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996;

(4) Issue within twenty-four hours, for all claims filed electronically, confirmation of receiving a claim for reimbursement;

(5) When processing claims, accept all codes, including modifiers, that are included within the physician's current procedural terminology of the American Medical Association, as amended; the Health Care Financing Administration's common procedure coding system, as amended; the International Classification of Diseases 9th Revision Clinical Modification system, as amended; Diagnosis Related Group coding, as amended; and any additional procedure, diagnosis and treatment codes approved by the department of insurance. The department of insurance shall promulgate rules for the implementation of such standard codes and the approval of additional procedure, diagnosis and treatment codes; and

(6) During contract negotiations with providers and upon delivery of the final contract, provide a current fee schedule for provider reimbursement for all covered services for which the health care professional is contracted to provide and forward to the provider, at least thirty days in advance of the effective date of such modifications, all modifications to such fee schedule.

2. No health carrier shall request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the provider.

3. All health carriers shall provide access on the Internet to a current provider directory.

4. A health carrier shall inform an enrollee when the health carrier denies coverage of a health care service requested to be provided to such enrollee. The health carrier shall explain such denial of coverage in plain language that is easy for a layperson to understand.

5. Effective July 1, 2002, a health carrier shall issue to each enrollee an enrollee card which includes a telephone number for the plan, prescription drug information and

a brief description of the enrollee's type of health care plan. Such description shall include, but not be limited to, terms such as preferred provider organization, point of service, health maintenance organization or indemnity plan. Such enrollee card shall be reissued upon any change in the enrollee's benefits or coverage that impacts the information included on the card.

6. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2001, shall be invalid and void.

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