SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 651

91ST GENERAL ASSEMBLY

Reported from the Committee on Public Health and Welfare, January 24, 2002, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

2652S.03C

AN ACT

To repeal section 354.606, RSMo, relating to health care providers, and to enact in lieu thereof one new section relating to the same subject.

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

Section A. Section 354.606, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 354.606, to read as follows:

354.606. 1. **This act shall be known as the "Patient Freedom of Choice Act of 2002".**

2. A health carrier shall establish a mechanism by which the participating provider shall be notified on an ongoing basis of the specific covered health services for which the provider shall be responsible, including any limitations or conditions on services.

[2.**]** **3.** Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for enrollees. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or a person, other than the health carrier or intermediary, acting on behalf of the enrollee for services provided pursuant to this agreement. This agreement shall not prohibit the provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for

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

uncovered services delivered on a fee-for-service basis to enrollees. This agreement shall not prohibit a provider, except for a health care professional who is employed full time on the staff of a health carrier and has agreed to provide service exclusively to that health carrier's enrollees and no others, and an enrollee from agreeing to continue services solely at the expense of the enrollee, as long as the provider has clearly informed the enrollee that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy; including, but not limited to, collecting from any insurance carrier providing coverage to a covered person."

[3.**]** **4.** Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier's or intermediary's insolvency or other cessation of operations, covered services to enrollees shall continue through the period for which a premium has been paid to the health carrier on behalf of the enrollee or until the enrollee's discharge from an inpatient facility, whichever time is greater.

[4.**]** **5.** The contract provisions satisfying the requirements of subsections **[**2 and**]** 3 **and 4** of this section shall:

(1) Be construed in favor of the enrollee;

(2) Survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier; and

(3) Supersede any oral or written contrary agreement between a provider and an enrollee or the representative of an enrollee if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by subsections 2 and 3 of this section.

[5.**]** **6.** In no event shall a participating provider collect or attempt to collect from an enrollee any money owed to the provider by the health carrier nor shall a participating provider collect or attempt to collect from an enrollee any money in excess of the coinsurance, co-payments or deductibles. Failure of a health carrier to make timely payment of an amount owed to a provider in accordance with the provider's contract shall constitute an unfair claims settlement practice subject to sections 375.1000 to 375.1018, RSMo.

[6.**]** **7.** (1) A health carrier shall develop selection standards for participating primary care professionals and each participating health care professional specialty. Such standards shall be in writing and used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. Selection criteria shall not be established in a manner that will:

(a) Allow a health carrier to avoid a high-risk population by excluding a provider because such provider is located in a geographic area that contains a population presenting a risk of higher than average claims, losses or health services utilization; or

(b) Exclude a provider because such provider treats or specializes in treating a population

presenting a risk of higher than average claims, losses or health services utilization**; or**

(c) Deny a health care professional the opportunity to become a participating provider if such health care professional satisfies all of the selection standards established by the health carrier as defined in section 376.1350, RSMo, and if the health care professional is willing to accept the plan's operating terms and conditions, its schedule of fees, covered expenses, utilization regulations and quality standards.

(2) Paragraphs (a) **[**and**],** (b) and (c) of subdivision (1) of this subsection shall not be construed to prohibit a health carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the health carrier developed in compliance with sections 354.600 to 354.636.

(3) The provisions of sections 354.600 to 354.636 shall not require a health carrier, its intermediaries or the provider networks with which it contracts, to employ specific providers or types of providers, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

[7.**] 8.** A health carrier shall file its selection standards for participating providers with the director. A health carrier shall also file any subsequent changes to its selection standards with the director. The selection standards shall be made available to licensed health care providers.

[8.**] 9.** A health carrier shall notify a participating provider of the provider's responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

[9.**] 10.** No contract between a health carrier and a provider for the delivery of health care service, entered into or renewed after August 28, 2001, shall require the mandatory use of a hospitalist. For purposes of this subsection, "hospitalist" means a physician who becomes a physician of record at a hospital for a patient of a participating provider and who may return the care of the patient to that participating provider at the end of hospitalization.

[10.**] 11.** A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to an enrollee.

[11.**] 12.** A health carrier shall not prohibit a participating provider from advocating in good faith on behalf of enrollees within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.

[12.**] 13.** A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care but shall not disclose individual identities, or investigating the grievances or complaints of enrollees, and to comply with the applicable state and federal laws related to the confidentiality of medical or

health records.

[13.**]** **14.** The rights and responsibilities of a provider under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

[14.**]** **15.** A health carrier shall be responsible for ensuring that a participating provider furnishes covered benefits to all enrollees without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in a publicly financed program of health care service.

[15.**]** **16.** A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, co-payments or deductibles from enrollees pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify enrollees of their personal financial obligations for noncovered services.

[16.**]** **17.** A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that may jeopardize patient health or welfare.

[17.**]** **18.** A health carrier shall establish a mechanism by which a participating provider may determine in a timely manner whether a person is covered by the carrier.

[18.**]** **19.** A health carrier shall not discriminate between health care professionals when selecting such professionals for enrollment in the network or when referring enrollees for health care services to be provided by such health care professional who is acting within the scope of his professional license.

[19.**]** **20.** A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

[20.**]** **21.** A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or sections 354.600 to 354.636.