SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 1103

93RD GENERAL ASSEMBLY

Reported from the Committee on Insurance Policy May 2, 2006 with recommendation that House Committee Substitute for Senate Bill No. 1103 Do Pass. Referred to the Committee on Rules pursuant to Rule 25(26)(f).

STEPHEN S. DAVIS, Chief Clerk

5320L.02C

AN ACT

To repeal section 354.430, RSMo, and to enact in lieu thereof three new sections relating to the issuance of health insurance coverage evidence.

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

Section A. Section 354.430, RSMo, is repealed and three new sections enacted in lieu thereof, to be known as sections 191.890, 354.430, and 1, to read as follows:

191.890. 1. As used in this section, the following terms mean:

(1) "Anatomic pathology services", histopathology or surgical pathology, cytopathology, hermatology, subcellular pathology and molecular pathology, and blood banking services performed by pathologists;

(2) "Cytopathology", the examination of cells from fluids, aspirates, washings, brushings, or smears, including the Pap test examination performed by a physician or under the supervision of a physician;

(3) "Hematology", the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician or under the supervision of a physician, and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist;

(4) "Histopathology" or "surgical pathology", the gross and microscopic examination and histologic processing of organ tissue performed by a physician or under the supervision of a physician.

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

2. Except as provided in subsection 5 of this section, no licensed practitioner in this state shall, directly or indirectly, charge, bill, or otherwise solicit payment for anatomic pathology services unless such services are rendered personally by the licensed practitioner or under such licensed practitioner's direct supervision in accordance with Section 353 of the Public Health Service Act, 42 U.S.C. Section 263a.

3. No patient, insurer, third-party payor, hospital, public health clinic, or nonprofit health clinic shall be required to reimburse any licensed practitioner for claims submitted in violation of this section.

4. Nothing in this section shall be construed as mandating the assignment of benefits for anatomic pathology services.

5. Nothing in this section shall prohibit billing of a referring laboratory for anatomic pathology services when a sample or samples must be sent to another specialist; except that, for purposes of this subsection, "referring laboratory" does not include a laboratory or a physician's office or group practice that does not perform the technical or professional component of the anatomic pathology service involved.

6. The respective state licensing boards having jurisdiction over any practitioner who may request or provide anatomical pathology services may revoke, suspend, or deny renewal of the license of any practitioner who violates the provisions of this section.

354.430. 1. Every enrollee residing in this state is entitled to evidence of coverage. If the enrollee obtains coverage through an insurance policy or a contract issued by a health services corporation, whether by option or otherwise, the insurer or the health services corporation shall issue the evidence of coverage. Otherwise the health maintenance organization shall issue the evidence of coverage.

2. No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with the director.

3. An evidence of coverage shall contain:

(1) No provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive, or which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in subsection 1 of section 354.460; and

(2) A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

(a) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(b) Any limitations on the services, kind of services, benefits**,** or kinds of benefits to be provided, including any deductible or co-payment**, coinsurance, or other cost-sharing** feature**,**

which feature shall be as requested by the group sponsor or, in the case of nongroup coverage, the individual certificate holder;

(c) Where and in what manner information is available as to how services may be obtained;

(d) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts; and

(e) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints, including the health maintenance organization's toll-free customer service number and the department of insurance's consumer complaint hot line number.

4. Any subsequent change in an evidence of coverage may be made in a separate document issued to the enrollee.

5. A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, shall be subject to the filing of subsection 2 of this section unless it is subject to the jurisdiction of the director under the laws governing health insurance or health services corporations, in which event the filing provisions of those laws shall apply.

Section 1. The rates of payment included in a contract between a health maintenance organization and a provider that was entered into prior to August 28, 2006, shall not apply to enrollees who purchase coverage from the health maintenance organization effective on or after August 28, 2006, if that coverage has an enrollee deductible and/or coinsurance obligation that is higher than was authorized by law or regulation immediately prior to August 28, 2006. The rates of payment for such enrollees shall be determined by contractual terms established by negotiation between the health maintenance organization and providers.

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