SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE BILL NO. 817

94TH GENERAL ASSEMBLY

Reported from the Special Committee on Health Insurance May 6, 2008 with recommendation that House Committee Substitute for Senate Substitute for Senate Bill No. 817 Do Pass. Referred to the Committee on Rules pursuant to Rule 25(21)(f).

D. ADAM CRUMBLISS, Chief Clerk

3320L.07C

AN ACT

To repeal sections 191.227 and 354.618, RSMo, and to enact in lieu thereof four new sections relating to anatomic pathology and vision services.

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

Section A. Sections 191.227 and 354.618, RSMo, are repealed and four new sections enacted in lieu thereof, to be known as sections 191.227, 191.890, 354.618, and 354.619, to read as follows:

191.227. 1. All physicians, chiropractors, hospitals, dentists, and other duly licensed practitioners in this state, herein called "providers", shall, upon written request of a patient, or guardian or legally authorized representative of a patient, furnish a copy of his or her record of that patient's health history and treatment rendered to the person submitting a written request, except that such right shall be limited to access consistent with the patient's condition and sound therapeutic treatment as determined by the provider. Beginning August 28, 1994, such record shall be furnished within a reasonable time of the receipt of the request therefor and upon payment of a fee as provided in this section.

2. Health care providers may condition the furnishing of the patient's health care records to the patient, the patient's authorized representative or any other person or entity authorized by law to obtain or reproduce such records upon payment of a fee for:

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.

(1) Copying, in an amount **[**not more than seventeen**] of nineteen** dollars and **[**five**] thirty-one** cents plus **[**forty**] forty-six** cents per page for the cost of supplies and labor;

(2) Postage, to include packaging and delivery cost; and

(3) **Certification and** notary fee**[**, not to exceed two**] of eight** dollars, if **certification is** requested.

3. Notwithstanding provisions of this section to the contrary, providers may charge for the reasonable cost of all duplications of health care record material or information which cannot routinely be copied or duplicated on a standard commercial photocopy machine.

4. The transfer of the patient's record done in good faith shall not render the provider liable to the patient or any other person for any consequences which resulted or may result from disclosure of the patient's record as required by this section.

5. Effective February first of each year, the fees listed in subsection 2 of this section shall be increased or decreased annually based on the annual percentage change in the unadjusted, U.S. city average, annual average inflation rate of the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). The current reference base of the index, as published by the Bureau of Labor Statistics of the United States Department of Labor, shall be used as the reference base. For purposes of this subsection, the annual average inflation rate shall be based on a twelve-month calendar year beginning in January and ending in December of each preceding calendar year. The department of health and senior services shall report the annual adjustment and the adjusted fees authorized in this section on the department's Internet web site by February first of each year.

191.890. 1. For purposes of this section, the term "anatomic pathology services" means:

(1) "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;

(2) "Cytopathology", the microscopic 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 licensed physician, and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist;

(4) Subcellular pathology and molecular pathology; and

(5) Blood-banking services performed by pathologists.

2. As used in this section, "health care benefit program" means any public or private plan or contract under which any medical benefit, item, or service is provided to any individual.

3. As used this section, "referring laboratory" does not include a laboratory of a physician's office or group practice that does not perform the professional component of the anatomic pathology service involved.

4. Except as provided under subsection 6 of this section, no licensed health care professional in the state shall, directly or indirectly, charge, bill, or otherwise solicit payment for anatomic pathology services unless such services were rendered personally by the licensed health care professional or under the licensed health care professional's direct supervision in accordance with Section 353 of the Public Health Service Act, 42 U.S.C. 263a.

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

6. The provisions of this section do not prohibit the billing of anatomic pathology services:

(1) To a referring laboratory, or by a referring laboratory, in instances where a sample or samples must be sent to another specialist;

(2) By a hospital, public health clinic, or non-profit health clinic;

(3) To a referring physician, or by a referring physician, who has provided written confirmation to the physician or laboratory providing the anatomic pathology service that the patient is not covered under a health care benefit program;

(4) By any governmental agency or their specified public or private agent.

7. Any referring physician billing a patient not covered by a health care benefit program for anatomic pathology services shall disclose in the bill to the patient:

(1) The name and address of the physician or laboratory providing the anatomic pathology service for the patient; and

(2) The net amount or amounts paid or to be paid to the physician or laboratory for each anatomic pathology service provided for the patient.

8. Any referring physician billing a patient not covered by a health care benefit program for anatomic pathology services shall not markup, or charge a commission, or make a profit on, or directly or indirectly increase, the amount subject to disclosure under subdivision (2) of subsection 7 of this section.

9. The respective state licensing boards having jurisdiction over any health care professional who may request or provide anatomic pathology services may revoke,

suspend, or deny renewal of the license of any health care professional who violates the provisions of this section.

10. Nothing in this section shall be construed to:

(1) Prohibit a referring physician from sending a patient's specimen to any laboratory providing anatomic pathology services;

(2) Mandate the billing of any patient not covered under a health care benefit program.

354.618. 1. A health carrier shall be required to offer as an additional health plan, an open referral health plan whenever it markets a gatekeeper group plan as an exclusive or full replacement health plan offering to a group contract holder:

(1) In the case of group health plans offered to employers of fifty or fewer employees, the decision to accept or reject the additional open referral plan offering shall be made by the group contract holder. For health plans marketed to employers of over fifty employees, the decision to accept or reject shall be made by the employee;

(2) Contracts currently in existence shall offer the additional open referral health plan at the next annual renewal after August 28, 1997; however, multiyear group contracts need not comply until the expiration of their current multiyear term unless the group contract holder elects to comply before that time;

(3) If an employer provides more than one health plan to its employees and at least one is an open referral plan, then all health benefit plans offered by such employer shall be exempt from the requirements of this section.

2. For the purposes of this act, the following terms shall mean:

(1) "Open referral plan", a plan in which the enrollee is allowed to obtain treatment for covered benefits without a referral from a primary care physician from any person licensed to provide such treatment;

(2) "Gatekeeper group plan", a plan in which the enrollee is required to obtain a referral from a primary care professional in order to access specialty care.

3. Any health benefit plan provided pursuant to the Medicaid program shall be exempt from the requirements of this section.

4. A health carrier shall have a procedure by which a female enrollee may seek the health care services of an obstetrician/gynecologist at least once a year without first obtaining prior approval from the enrollee's primary care provider if the benefits are covered under the enrollee's health benefit plan, and the obstetrician/gynecologist is a member of the health carrier's network. In no event shall a health carrier be required to permit an enrollee to have health care services delivered by a nonparticipating obstetrician/gynecologist. An obstetrician/gynecologist who delivers health care services directly to an enrollee shall report such visit and health care services provided to the enrollee's primary care provider. A health

carrier may require an enrollee to obtain a referral from the primary care physician, if such enrollee requires more than one annual visit with an obstetrician/gynecologist.

5. [Except for good cause, a health carrier shall be prohibited either directly, or indirectly through intermediaries, from discriminating between eye care providers when selecting among providers of health services for enrollment in the network and when referring enrollees for health services provided within the scope of those professional licenses and when reimbursing amounts for covered services among persons duly licensed to provide such services. For the purposes of this section, an eye care provider may be either an optometrist licensed pursuant to chapter 336, RSMo, or a physician who specializes in opthamologic medicine, licensed pursuant to chapter 334, RSMo.

6.] Nothing contained in this section shall be construed as to require a health carrier to pay for health care services not provided for in the terms of a health benefit plan.

[7.] **6.** Any health carrier, which is sponsored by a federally qualified health center and is presently in existence and which has been in existence for less than three years shall be exempt from this section for a period not to exceed two years from August 28, 1997.

[8.] **7.** A health carrier shall not be required to offer the direct access rider for a group contract holder's health benefit plan if the health benefit plan is being provided pursuant to the terms of a collective bargaining agreement with a labor union, in accordance with federal law and the labor union has declined such option on behalf of its members.

[9.] **8.** Nothing in this act shall be construed to preempt the employer's right to select the health care provider pursuant to section 287.140, RSMo, in a case where an employee incurs a work-related injury covered by the provisions of chapter 287, RSMo.

[10.] **9.** Nothing contained in this act shall apply to certified managed care organizations while providing medical treatment to injured employees entitled to receive health benefits under chapter 287, RSMo, pursuant to contractual arrangements with employers, or their insurers, under section 287.135, RSMo.

354.619. 1. Except for good cause, a health carrier shall be prohibited either directly or indirectly through intermediaries from discriminating between eye care providers when selecting among providers of health services for enrollment in the network and when referring enrollees for health care services provided within the scope of those professional licenses and when reimbursing amounts for covered services among persons duly licensed to provide such services. For the purposes of this section, an eye care provider may be either an optometrist licensed under chapter 336, RSMo, or a physician who specializes in ophthalmologic medicine and who is licensed under chapter 334, RSMo.

2. A health carrier shall not directly or indirectly through intermediaries refuse to select an eye care provider for the network solely on the grounds that:

(1) Not all eye care providers in a group practice agree to participate in the health carrier's provider network; or

(2) The provider is not a retailer of frames and corrective lenses.

3. If optometric services are being provided in connection to a treatment plan for corrective surgery, a health carrier shall not directly or indirectly through intermediaries refuse to select an eye care provider for the network, refuse to refer an enrollee for health services provided within the scope of an eye care provider's license, or reimburse for covered services in a discriminatory manner.

4. A health carrier shall not require a licensed optometrist who provides basic medical eye care to participate solely through an intermediary if such health carrier permits ophthalmologists to contract directly with the health carrier.

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