

SECOND REGULAR SESSION

[C O R R E C T E D]

[P E R F E C T E D]

SENATE BILL NO. 581

98TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SCHAAF.

Pre-filed December 1, 2015, and ordered printed.

Read 2nd time January 7, 2016, and referred to the Committee on Veterans' Affairs and Health.

Reported from the Committee January 28, 2016, with recommendation that the bill do pass.

Taken up for Perfection February 11, 2016. Bill declared Perfected and Ordered Printed, as amended.

ADRIANE D. CROUSE, Secretary.

4451S.01P

AN ACT

To amend chapters 191 and 376, RSMo, by adding thereto two new sections relating to health care price transparency.

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

Section A. Chapters 191 and 376, RSMo, are amended by adding thereto
2 two new sections, to be known as sections 191.875 and 376.2020, to read as
3 follows:

191.875. 1. This section shall be known as the "Health Care Cost
2 Reduction and Transparency Act".

3 2. As used in this section, the following terms shall mean:

4 (1) "Department", the department of health and senior services;

5 (2) "DRG", diagnosis related group;

6 (3) "Estimate of cost", an estimate based on the information
7 entered and assumptions about typical utilization and costs for health
8 care services. Such estimates of cost shall encompass only those
9 services within the direct control of the health care provider and shall
10 include the following:

11 (a) The amount that will be charged to a patient for the health
12 services if all charges are paid in full without a public or private third
13 party paying for any portion of the charges;

14 (b) The average negotiated settlement on the amount that will be
15 charged to a patient required to be provided in paragraph (a) of this
16 subdivision;

17 (c) The amount of any MO HealthNet reimbursement for the
18 health care services, including claims and pro rata supplemental
19 payments, if known;

20 (d) The amount of any Medicare reimbursement for the medical
21 services, if known; and

22 (e) The amount of any insurance copayments for the health
23 benefit plan of the patient, if known;

24 (4) "Health care provider", any ambulatory surgical center,
25 assistant physician, chiropractor, clinical psychologist, dentist,
26 hospital, long-term care facility, nurse anesthetist, optometrist,
27 pharmacist, physical therapist, physician, physician assistant,
28 podiatrist, registered nurse, or other licensed health care facility or
29 professional providing health care services in this state;

30 (5) "Health carrier", an entity as such term is defined under
31 section 376.1350;

32 (6) "Hospital", as such term is defined under section 197.020;

33 (7) "Insurance costs", an estimate of cost of covered services
34 provided by a health carrier based on a specific insured's coverage and
35 health care services to be provided. Such insurance cost shall include:

36 (a) The average negotiated reimbursement amount to any health
37 care provider;

38 (b) Any deductibles, copayments, or coinsurance amounts,
39 including those whose disclosure is mandated under section 376.446;
40 and

41 (c) Any amounts not covered under the health benefit plan;

42 (8) "Public or private third party", a state government, the
43 federal government, employer, health carrier, third-party
44 administrator, or managed care organization.

45 3. On or after July 1, 2017, any patient or consumer of health
46 care services who makes a written request for an estimate of the cost
47 of health care services from a health care provider shall be provided
48 such estimate no later than five business days after receiving such
49 request, except when the requested information is posted on the
50 department's website under subsection 8 of this section. Any patient
51 or consumer of health care services who makes a written request for
52 the insurance costs from such patient's or consumer's health carrier
53 shall be provided such insurance costs no later than five business days

54 after receiving such request. The provisions of this subsection shall not
55 apply to emergency health care services.

56 4. Health care providers, and the department under subsection
57 8 of this section, shall include with any estimate of costs the following:
58 "Your estimated cost is based on the information entered and
59 assumptions about typical utilization and costs. The actual amount
60 billed to you may be different from the estimate of costs provided to
61 you. Many factors affect the actual bill you will receive, and this
62 estimate of costs does not account for all of them. Additionally, the
63 estimate of costs is not a guarantee of insurance coverage. You will be
64 billed at the health care provider's charge for any service provided to
65 you that is not a covered benefit under your plan. Please check with
66 your insurance company to receive an estimate of the amount you will
67 owe under your plan or if you need help understanding your benefits
68 for the service chosen."

69 5. Health carriers shall include with any insurance costs the
70 following: "Your insurance costs are based on the information entered
71 and assumptions about typical utilization and costs. The actual amount
72 of insurance costs and the amount billed to you may be different from
73 the insurance costs provided to you. Many factors affect the actual
74 insurance costs, and the insurance costs provided do not account for all
75 of them. Additionally, the insurance costs provided are limited to the
76 specific information provided and are not a guarantee of insurance
77 coverage for additional services. You will be billed at the health care
78 provider's charge for any service provided to you that is not a covered
79 benefit under your plan. You may contact us if you need further
80 assistance in understanding your benefits for the service chosen."

81 6. Each health care provider shall also make available the
82 percentage or amount of any discounts for cash payment of any charges
83 incurred through the health care provider's website or by making it
84 available at the health care provider's location.

85 7. Nothing in this section shall be construed as violating any
86 health care provider contract provisions with a health carrier that
87 prohibit disclosure of the health care provider's fee schedule with a
88 health carrier to third parties.

89 8. The department shall make available to the public on its
90 website the most current price information it receives from hospitals

91 under subsections 9 and 10 of this section. The department shall
92 provide this information in a manner that is easily understood by the
93 public and meets the following minimum requirements:

94 (1) Information for each participating hospital shall be listed
95 separately and hospitals shall be listed in groups by category as
96 determined by the department in rules adopted under this section; and

97 (2) Information for each hospital outpatient department shall be
98 listed separately.

99 9. Beginning with the quarter ending June 30, 2017, and
100 quarterly thereafter, each participating hospital shall provide to the
101 department, in the manner and format determined by the department,
102 the following information about the one hundred most frequently
103 reported admissions by DRG for inpatients as established by the
104 department:

105 (1) The amount that will be charged to a patient for each DRG if
106 all charges are paid in full without a public or private third party
107 paying for any portion of the charges;

108 (2) The average negotiated settlement on the amount that will be
109 charged to a patient required to be provided in subdivision (1) of this
110 subsection;

111 (3) The amount of MO HealthNet reimbursement for each DRG,
112 including claims and pro rata supplemental payments; and

113 (4) The amount of Medicare reimbursement for each DRG.

114 A hospital shall not report or be required to report the information
115 required by this subsection for any of the one hundred most frequently
116 reported admissions where the reporting of that information
117 reasonably could lead to the identification of the person or persons
118 admitted to the hospital in violation of the federal Health Insurance
119 Portability and Accountability Act of 1996 (HIPAA) or other federal law.

120 10. Beginning with the quarter ending June 30, 2017, and
121 quarterly thereafter, each participating hospital shall provide to the
122 department, in a manner and format determined by the department,
123 information on the total costs for the twenty most common outpatient
124 surgical procedures and the twenty most common imaging procedures,
125 by volume, performed in hospital outpatient settings. Participating
126 hospitals shall report this information in the same manner as required
127 by subsection 9 of this section, provided that hospitals shall not report

128 or be required to report the information required by this subsection
129 where the reporting of that information reasonably could lead to the
130 identification of the person or persons admitted to the hospital in
131 violation of HIPAA or other federal law.

132 11. A hospital shall provide the information specified under
133 subsections 9 and 10 of this section to the department. A hospital
134 which does so shall not be required to provide that information
135 pursuant to subsection 3 of this section.

136 12. Any data disclosed to the department by a hospital under
137 subsections 9 and 10 of this section shall be the sole property of the
138 hospital that submitted the data. Any data or product derived from the
139 data disclosed under subsections 9 and 10 of this section, including a
140 consolidation or analysis of the data, shall be the sole property of the
141 state. Any proprietary information received by the department shall
142 be a proprietary interest and may be closed under the provisions of
143 subdivision (15) of section 610.021. The department shall not allow
144 information it receives or discloses under subsections 9 and 10 of this
145 section to be used by any person or entity for commercial purposes.

146 13. The department shall promulgate rules to implement the
147 provisions of this section. The rules relating to subsections 8 to 12 of
148 this section shall include all of the following:

149 (1) The one hundred most frequently reported DRGs for
150 inpatients for which participating hospitals will provide the data
151 required under subsection 9 of this section;

152 (2) Specific categories by which hospitals shall be grouped for
153 the purpose of disclosing this information to the public on the
154 department's website; and

155 (3) The twenty most common outpatient surgical procedures and
156 the twenty most common imaging procedures, by volume, performed in
157 a hospital outpatient setting required under subsection 10 of this
158 section.

159 Any rule or portion of a rule, as that term is defined in section 536.010
160 that is created under the authority delegated in this section shall
161 become effective only if it complies with and is subject to all of the
162 provisions of chapter 536, and, if applicable, section 536.028. This
163 section and chapter 536 are nonseverable and if any of the powers
164 vested with the general assembly pursuant to chapter 536, to review, to

165 delay the effective date, or to disapprove and annul a rule are
166 subsequently held unconstitutional, then the grant of rulemaking
167 authority and any rule proposed or adopted after August 28, 2016, shall
168 be invalid and void.

376.2020. 1. For purposes of this section, the following terms
2 shall mean:

3 (1) "Contractual payment amount" or "payment amount", shall
4 mean the total amount a health care provider is to be paid for
5 providing a given health care service pursuant to a contract with a
6 health carrier, and includes both the portions to be paid by the patient
7 and by the health carrier. It is commonly referred to as the allowable
8 amount;

9 (2) "Enrollee", shall have the same meaning ascribed to it in
10 section 376.1350;

11 (3) "Health care provider", shall have the same meaning ascribed
12 to it in section 376.1350;

13 (4) "Health care service", shall have the same meaning ascribed
14 to it in section 376.1350;

15 (5) "Health carrier", shall have the same meaning ascribed to it
16 in section 376.1350.

17 2. No provision in a contract in existence or entered into,
18 amended, or renewed on or after August 28, 2016, between a health
19 carrier and a health care provider shall be enforceable if such
20 contractual provision prohibits, conditions, or in any way restricts any
21 party to such contract from disclosing to an enrollee, patient, potential
22 patient, or such person's parent or legal guardian, the contractual
23 payment amount for a health care service if such payment amount is
24 less than the health care provider's usual charge for the health care
25 service, and if such contractual provision prevents the determination
26 of the potential out-of-pocket cost for the health care service by the
27 enrollee, patient, potential patient, parent, or legal guardian.

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