FIRST REGULAR SESSION

SENATE BILL NO. 138

99TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SATER.

Pre-filed December 1, 2016, and ordered printed.

ADRIANE D. CROUSE, Secretary.

0443S.01I

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to predetermination of health care benefits, with an effective date.

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

Section A. Chapter 376, RSMo, is amended by adding thereto one new section, to be known as section 376.1475, to read as follows:

376.1475. 1. This section shall be known as and may be cited as the "Predetermination of Health Care Benefits Act".

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

(1) "Administrative simplification provision", transaction and code standards promulgated pursuant to the Health Insurance Portability Act of 1996 (HIPAA), Public Law 104-191, and 45 CFR 160 and 162;

(2) "Director", the director of the department of insurance, financial institutions and professional registration;

(3) "Health benefit plan" and "health care provider", shall have the same meanings as those terms are defined in section 376.1350;

(4) "Health care clearinghouse", the same meaning as the term is defined in 45 CFR 160.103;

(5) "Payment", only a deductible or coinsurance payment and shall not include a co-payment;

(6) "Standard electronic transactions", electronic claim and remittance advice transactions created by the accredited standards committee X12 in the format of ASC X12 837I, ASC X12 837P, or ASC X12 835, or any of their respective successors.

3. Health benefit plans that receive an electronic health care

predetermination request from a health care provider consistent with the requirements set forth in subsection 6 of this section shall provide the requesting health care provider information on the amounts of expected benefits coverage on the procedures specified in the request that is accurate at the time of the health benefit plan's response.

4. Any predetermination response provided by a health benefit plan under this section in good faith shall be deemed to be an estimate only and shall not be binding upon the health benefit plan with regard to the final amount of benefits actually provided by the health benefit plan.

5. The amounts for the referenced services in subsection 3 of this section shall include:

(1) The amount the patient will be expected to pay, clearly identifying any deductible amount, coinsurance, and co-payment;

(2) The amount the healthcare provider will be paid;

(3) The amount the institution will be paid; and

(4) Whether any payments will be reduced, but not to zero dollars, or increased from the agreed fee schedule amounts, and if so, the health care policy that identifies why the payments will be reduced or increased.

6. The health care predetermination request and predetermination response shall be conducted in accordance with administrative simplification provisions using the currently applicable standard electronic transactions, without regard to whether this transaction is mandated by HIPAA. It shall also comply with any rules promulgated by the director, without regard to whether these rules are mandated by HIPAA. To the extent HIPAA-mandated electronic claim and remittance transactions are modified to include predetermination, the provisions of this section shall not apply to health benefit plans which provide this information under HIPAA.

7. The health benefit plan's predetermination response to the health care predetermination request shall be returned using the same transmission method as that of the submission. This includes a real time response for a real time request.

8. A health care clearinghouse that contracts with a health care provider shall be required to conduct a transaction as described in subsections 5, 6, and 7 of this section if requested by the health care

provider.

9. Nothing in this act precludes the collection of payment prior to receiving health benefit services once a health benefit plan has fulfilled any predetermination request.

10. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months or less duration or any other supplemental policy.

11. The director shall adopt rules and regulations necessary to carry out the provisions of this section.

12. Any rule or portion of a rule, as that term is defined in section 536.010 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, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, 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, 2017, shall be invalid and void.

Section B. This act shall become effective July 1, 2018.

✓