SECOND REGULAR SESSION

[P E R F E C T E D**]**

SENATE SUBSTITUTE FOR

SENATE BILL NO. 982

99TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR WIELAND.

Offered April 17, 2018.

Senate Substitute adopted, April 17, 2018.

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ADRIANE D. CROUSE, Secretary.

6265S.09P

AN ACT

To repeal sections 376.427, 376.1350, and 376.1367, RSMo, and to enact in lieu thereof five new sections relating to payments for health care services.

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

Section A. Sections 376.427, 376.1350, and 376.1367, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 376.427, 376.690, 376.1063, 376.1350, and 376.1367, to read as follows:

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

(1) "Health care services", medical, surgical, dental, podiatric, pharmaceutical, chiropractic, licensed ambulance service, and optometric services;

(2) "Insured", any person entitled to benefits under a contract of accident and sickness insurance, or medical-payment insurance issued as a supplement to liability insurance but not including any other coverages contained in a liability or a workers' compensation policy, issued by an insurer;

(3) "Insurer", any person, reciprocal exchange, interinsurer, fraternal benefit society, health services corporation, self-insured group arrangement to the extent not prohibited by federal law, or any other legal entity engaged in the business of insurance;

(4) "Provider", a physician, hospital, dentist, podiatrist, chiropractor, pharmacy, licensed ambulance service, or optometrist, licensed by this state.

2. Upon receipt of an assignment of benefits made by the insured to a

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

provider, the insurer shall issue the instrument of payment for a claim for payment for health care services in the name of the provider. All claims shall be paid within thirty days of the receipt by the insurer of all documents reasonably needed to determine the claim.

3. Nothing in this section shall preclude an insurer from voluntarily issuing an instrument of payment in the single name of the provider.

4. **Except as provided in subsection 5 of this section,** this section shall not require any insurer, health services corporation, health maintenance corporation or preferred provider organization which directly contracts with certain members of a class of providers for the delivery of health care services to issue payment as provided pursuant to this section to those members of the class which do not have a contract with the insurer.

5. When a patient's health benefit plan does not include or require payment to out-of-network providers for all or most covered services, which would otherwise be covered if the patient received such services from a provider in the carrier's network, including but not limited to health maintenance organization plans, as such term is defined in section 354.400, or a health benefit plan offered by a carrier consistent with subdivision (19) of section 376.426, payment for all services shall be made directly to the providers when the health carrier has authorized such services to be received from a provider outside the carrier's network.

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

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged;

2. Health care professionals shall send any U.S. Centers of

Medicare and Medicaid Services Form 1500, or its successor form, for charges incurred for unanticipated out-of-network care to the patient's health carrier.

(1) The health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's bill.

(2) If the health care professional declines the health carrier's initial offer of payment, the health carrier and health care professional shall negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care.

(3) If the health carrier and health care professional do not agree to a reimbursement amount within ninety days of when the health carrier first offered a reimbursement under subdivision (1) of this subsection, the dispute shall be submitted to the department for a decision through an arbitration process as specified in subsection 4 of this section.

(4) No health care professional shall send a bill to the patient for any difference between the payment received and the payment that would have been received if the payment was based on the rate charged by the health care professional.

3. When unanticipated out-of-network care is provided, the health care professional may bill a patient for no more than the cost-sharing requirements that would be applicable if the services had been provided by an in-network professional.

(1) Cost-sharing requirements shall be based on the payment received by the health care professional as determined under subsection 2 of this section.

(2) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within thirty business days of receiving a bill from the health care professional for services provided.

(3) For purposes of an enrollee's deductible and out-of-pocket maximum, cost-sharing payments to the health care professional shall be treated by the health carrier as though they were paid to an in-network health care professional.

4. The director of the department of insurance, financial institutions and professional registration shall ensure access to an

arbitration process when a health care professional and health carrier can not agree to a reasonable reimbursement under subdivision (2) of subsection 2 of this section. At the conclusion of such arbitration process, the arbitrator shall issue a binding decision. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

5. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

6. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section. The costs of arbitration shall be shared equally between the health care professional and health carrier.

7. This section shall take effect on January 1, 2019.

8. The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section. 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, 2018, shall be invalid and void.

376.1063. 1. Health carriers, as such term is defined in section 376.1350, and contracting entities, as such term is defined in section 376.1060, shall update their websites at least once per month with any changes to their provider network, including changes to whether providers are in-network or out-of-network.

2. Upon notification by an enrollee, health carriers and contracting entities shall reprocess as an in-network claim any claim for services provided by a provider whose status has changed from in-network to out-of-network where the service was provided after the network change went into effect but before the change was posted as required under subsection 1 of this section. This subsection shall not apply where the health carrier or contracting entity notified the enrollee of the network change prior to the service being provided, or where the health carrier or contracting entity is able to verify that their website displayed the correct provider network status at the time the service was provided.

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information

provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

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

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity**, regardless of the final diagnosis that is given,** that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or

safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

(18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services; except that, health benefit plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(19) "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

(20) "Health care provider" or "provider", a health care professional or a facility;

(21) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

(22) "Health carrier", an entity subject to the insurance laws and

regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services; except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

(24) "Managed care plan", a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

(25) "Participating provider", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier;

(26) "Peer-reviewed medical literature", a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

(27) "Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

(28) "Prospective review", utilization review conducted prior to an admission or a course of treatment;

(29) "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

(30) "Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(31) "Stabilize", with respect to an emergency medical condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred;

(32) "Standard reference compendia":

(a) The American Hospital Formulary Service-Drug Information; or

(b) The United States Pharmacopoeia-Drug Information;

(33) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

(34) "Utilization review organization", a utilization review agent as defined in section 374.500.

376.1367. When conducting utilization review or making a benefit determination for emergency services:

(1) A health carrier shall cover emergency services necessary to screen and stabilize an enrollee**, as determined by the treating emergency department health care provider,** and shall not require prior authorization of such services;

(2) Coverage of emergency services shall be subject to applicable co-payments, coinsurance and deductibles;

(3) **Before a health carrier denies payment for an emergency medical service based on the absence of an emergency medical condition, it shall review the enrollee's medical record regarding the emergency medical condition at issue. If a health carrier requests records for a potential denial where emergency services were rendered,**

the health care provider shall submit the record of the emergency services to the carrier within forty-five days, or the claim shall be subject to section 376.383. The health carrier's review of emergency services shall be completed by a board-certified physician licensed under chapter 334 to practice medicine in this state;

(4) When an enrollee receives an emergency service that requires immediate post evaluation or post stabilization services, a health carrier shall provide an authorization decision within sixty minutes of receiving a request; if the authorization decision is not made within **[**thirty**]** **sixty** minutes, such services shall be deemed approved**;**

(5) When a patient's health benefit plan does not include or require payment to out-of-network health care providers for emergency services including but not limited to health maintenance organization plans, as defined in section 354.400, or a health benefit plan offered by a health carrier consistent with subdivision (19) of section 376.426, payment for all emergency services as defined in section 376.1350 necessary to screen and stabilize an enrollee shall be paid directly to the health care provider by the health carrier. Additionally, any services authorized by the health carrier for the enrollee once the enrollee is stabilized shall also be paid by the health carrier directly to the health care provider.

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