FIRST REGULAR SESSION

SENATE BILL NO. 261

101ST GENERAL ASSEMBLY

INTRODUCED BY SENATOR WILLIAMS.

1123S.01I ADRIANE D. CROUSE, Secretary

AN ACT

To repeal section 376.690, RSMo, and to enact in lieu thereof one new section relating to unanticipated out-of-network medical care.

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

Section A. Section 376.690, RSMo, is repealed and one new
2 section enacted in lieu thereof, to be known as section 376.690,
3 to read as follows:

376.690. 1. As used in this section, the following
2 terms shall mean:
3 (1) **[**"Emergency medical condition", the same meaning
4 given to such term in section 376.1350;
5 (2)**]** "Facility", the same meaning given to such term
6 in section 376.1350;
7 **[**(3)**]** **(2)** "Health care professional", the same meaning
8 given to such term in section 376.1350;
9 **[**(4)**]** **(3)** "Health carrier", the same meaning given to
10 such term in section 376.1350;
11 **[**(5)**]** **(4)** "Unanticipated out-of-network care", health
12 care services received by a patient in an in-network
13 facility from an out-of-network health care professional
14 from the time the patient presents **[**with an emergency
15 medical condition**]** **at the in-network facility** until the time
16 the patient is discharged. **Such term shall also include a**
17 **referral or transfer from an in-network provider to an out-**
18 **of-network provider in a situation where the only provider**

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

19 **capable of rendering life-saving or life-sustaining**
20 **treatment to a patient is an out-of-network provider.**
21 2. (1) Health care professionals shall send any claim
22 for charges incurred for unanticipated out-of-network care
23 to the patient's health carrier within one hundred eighty
24 days of the delivery of the unanticipated out-of-network
25 care on a U.S. Centers of Medicare and Medicaid Services
26 Form 1500, or its successor form, or electronically using
27 the 837 HIPAA format, or its successor.
28 (2) Within forty-five processing days, as defined in
29 section 376.383, of receiving the health care professional's
30 claim, the health carrier shall offer to pay the health care
31 professional a reasonable reimbursement for unanticipated
32 out-of-network care based on the health care professional's
33 services. If the health care professional participates in
34 one or more of the carrier's commercial networks, the offer
35 of reimbursement for unanticipated out-of-network care shall
36 be the amount from the network which has the highest
37 reimbursement.
38 (3) If the health care professional declines the
39 health carrier's initial offer of reimbursement, the health
40 carrier and health care professional shall have sixty days
41 from the date of the initial offer of reimbursement to
42 negotiate in good faith to attempt to determine the
43 reimbursement for the unanticipated out-of-network care.
44 (4) If the health carrier and health care professional
45 do not agree to a reimbursement amount by the end of the
46 sixty-day negotiation period, the dispute shall be resolved
47 through an arbitration process as specified in subsection 4
48 of this section.
49 (5) To initiate arbitration proceedings, either the
50 health carrier or health care professional must provide

51 written notification to the director and the other party
52 within one hundred twenty days of the end of the negotiation
53 period, indicating their intent to arbitrate the matter and
54 notifying the director of the billed amount and the date and
55 amount of the final offer by each party. A claim for
56 unanticipated out-of-network care may be resolved between
57 the parties at any point prior to the commencement of the
58 arbitration proceedings. Claims may be combined for
59 purposes of arbitration, but only to the extent the claims
60 represent similar circumstances and services provided by the
61 same health care professional, and the parties attempted to
62 resolve the dispute in accordance with subdivisions (3) to
63 (5) of this subsection.
64 (6) No health care professional who sends a claim to a
65 health carrier under subsection 2 of this section shall send
66 a bill to the patient for any difference between the
67 reimbursement rate as determined under this subsection and
68 the health care professional's billed charge.
69 3. (1) When unanticipated out-of-network care is
70 provided, the health care professional who sends a claim to
71 a health carrier under subsection 2 of this section may bill
72 a patient for no more than the cost-sharing requirements
73 described under this section.
74 (2) Cost-sharing requirements shall be based on the
75 reimbursement amount as determined under subsection 2 of
76 this section.
77 (3) The patient's health carrier shall inform the
78 health care professional of its enrollee's cost-sharing
79 requirements within forty-five processing days of receiving
80 a claim from the health care professional for services
81 provided.

82 (4) The in-network deductible, **co-pay, coinsurance,**
83 and out-of-pocket maximum cost-sharing requirements shall
84 apply to the claim for the unanticipated out-of-network care.
85 4. The director shall ensure access to an external
86 arbitration process when a health care professional and
87 health carrier cannot agree to a reimbursement under
88 subdivision (3) of subsection 2 of this section. In order
89 to ensure access, when notified of a parties' intent to
90 arbitrate, the director shall randomly select an arbitrator
91 for each case from the department's approved list of
92 arbitrators or entities that provide binding arbitration.
93 The director shall specify the criteria for an approved
94 arbitrator or entity by rule. The costs of arbitration
95 shall be shared equally between and will be directly billed
96 to the health care professional and health carrier. These
97 costs will include, but are not limited to, reasonable time
98 necessary for the arbitrator to review materials in
99 preparation for the arbitration, travel expenses and
100 reasonable time following the arbitration for drafting of
101 the final decision.
102 5. At the conclusion of such arbitration process, the
103 arbitrator shall issue a final decision, which shall be
104 binding on all parties. The arbitrator shall provide a copy
105 of the final decision to the director. The initial request
106 for arbitration, all correspondence and documents received
107 by the department and the final arbitration decision shall
108 be considered a closed record under section 374.071.
109 However, the director may release aggregated summary data
110 regarding the arbitration process. The decision of the
111 arbitrator shall not be considered an agency decision nor
112 shall it be considered a contested case within the meaning
113 of section 536.010.

114 6. The arbitrator shall determine a dollar amount due
115 under subsection 2 of this section between one hundred
116 twenty percent of the Medicare-allowed amount and the
117 seventieth percentile of the usual and customary rate for
118 the unanticipated out-of-network care, as determined by
119 benchmarks from independent nonprofit organizations that are
120 not affiliated with insurance carriers or provider
121 organizations.
122 7. When determining a reasonable reimbursement rate,
123 the arbitrator shall consider the following factors if the
124 health care professional believes the payment offered for
125 the unanticipated out-of-network care does not properly
126 recognize:
127 (1) The health care professional's training,
128 education, or experience;
129 (2) The nature of the service provided;
130 (3) The health care professional's usual charge for
131 comparable services provided;
132 (4) The circumstances and complexity of the particular
133 case, including the time and place the services were
134 provided; and
135 (5) The average contracted rate for comparable
136 services provided in the same geographic area.
137 8. The enrollee shall not be required to participate
138 in the arbitration process. The health care professional
139 and health carrier shall execute a nondisclosure agreement
140 prior to engaging in an arbitration under this section.
141 9. The department of commerce and insurance may
142 promulgate rules and fees as necessary to implement the
143 provisions of this section, including but not limited to
144 procedural requirements for arbitration. Any rule or
145 portion of a rule, as that term is defined in section

146 536.010, that is created under the authority delegated in
147 this section shall become effective only if it complies with
148 and is subject to all of the provisions of chapter 536 and,
149 if applicable, section 536.028. This section and chapter
150 536 are nonseverable and if any of the powers vested with
151 the general assembly pursuant to chapter 536 to review, to
152 delay the effective date, or to disapprove and annul a rule
153 are subsequently held unconstitutional, then the grant of
154 rulemaking authority and any rule proposed or adopted after
155 August 28, 2018, shall be invalid and void.

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