FIRST REGULAR SESSION

SENATE BILL NO. 401

101ST GENERAL ASSEMBLY

INTRODUCED BY SENATOR ONDER.

1912S.01I ADRIANE D. CROUSE, Secretary

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to payments for health care services.

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 376.1347, to read as follows:

376.1347. 1. As used in this section, the following terms shall mean:

(1) "Claimant", any individual, corporation, association, partnership or other legal entity asserting a right to payment arising out of a contract or a contingency or loss covered under a health benefit plan, as defined in this section;

(2) "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 a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(3) "Health carrier", the same meaning as ascribed to such term in section 376.1350; except that for purposes of this section such term shall include any entity operating a

prepaid dental plan, as such term is defined in section 354.700, and any entity acting on behalf of the health carrier.

2. No health carrier shall modify a medical code on a claim for reimbursement in a way that results in a lower reimbursement amount. If a health carrier requires additional information to process the claim as submitted, the health carrier shall follow the process specified in section 376.383, provided that claims for emergency services as defined in section 376.1350 shall be subject to the provisions of section 376.1367.

3. No communication, including an explanation of benefits, by a health carrier to a patient regarding services the patient received from a health care provider shall state or imply:

(1) That a claim for reimbursement submitted by a claimant was inaccurate or otherwise inappropriate, unless there is clear evidence that the procedure code listed on the claim is not the procedure actually performed or that the procedure was not clinically appropriate; or

(2) That the claimant's charge was excessive, unless the charge to the patient for the service provided is greater than the claimant's usual fee for the service provided or greater than the fee allowed by the patient's health carrier for the service provided.

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