FIRST REGULAR SESSION

HOUSE BILL NO. 995

99TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE EGGLESTON.

1399H.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapter 376, RSMo, by adding thereto nine new sections relating to rates charged by health care providers.

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

Section A. Chapter 376, RSMo, is amended by adding thereto nine new sections, to be known as sections 376.525, 376.1140, 376.1142, 376.1144, 376.1146, 376.1148, 376.1150, 376.1152, and 376.1154, to read as follows:

376.525. Notwithstanding any other provision of law, the highest rate that a health care provider shall accept as payment in full for health care services from an uninsured individual or an individual not utilizing insurance to pay for such services shall be no greater than the lowest rate that the provider accepts from a health carrier as payment in full for the same or similar health care services.

376.1140. For the purposes of sections 376.1140 to 376.1154, the following terms shall mean:

(1) "Emergency condition", a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

(b) Serious impairment to such person's bodily functions;

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

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

(d) Serious disfigurement of such person; or

(e) A condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act, 42 U.S.C. 1395dd;

(2) "Emergency services", with respect to an emergency condition:

(a) A medical screening examination as required under Section 1867 of the Social Security Act, 42 U.S.C. 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(b) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under Section 1867 of the Social Security Act, 42 U.S.C. 1395dd, to stabilize the patient;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Insured", a patient covered under a health carrier's policy or contract;

(5) "Non-participating", not having a contract with a health carrier to provide health care services to an insured;

(6) "Participating", having a contract with a health carrier to provide health care services to an insured;

(7) "Patient", a person who receives health care services, including emergency services, in this state;

(8) "Surprise bill", a bill for health care services, other than emergency services, received by:

(a) An insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center, if a participating physician is unavailable or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided that, a surprise bill shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician;

(b) An insured for services rendered by a non-participating provider, if the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health carrier; or

(c) A patient who is not an insured for services rendered by a physician at a hospital or ambulatory surgical center, if the patient has not timely received all required disclosures;

(9) "Usual and customary cost", the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the department. The nonprofit organization shall not be affiliated with a health carrier.

376.1142. 1. The department shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The department shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The department shall promulgate regulations establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process of sections 376.1140 to 376.1154. To the extent practicable, the physician shall be licensed in this state.

2. The department may promulgate rules and regulations to implement the provisions of sections 376.1140 to 376.1154. 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.

376.1144. 1. With regard to emergency services billed under American Medical Association Current Procedural Terminology (CPT) codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and 99234 through 99236, the dispute resolution process established in sections 376.1140 to 376.1154 shall not apply if:

(1) The amount billed for any such CPT code meets the requirements set forth in subsection 3 of this section, after any applicable coinsurance, co-payment, and deductible; and

(2) The amount billed for any such CPT code does not exceed one hundred twenty percent of the usual and customary cost for such CPT code.

2. The health carrier shall ensure that an insured shall not incur any greater out-of-pocket costs for emergency services billed under a CPT code as set forth in this section

than the insured would have incurred if such emergency services were provided by a participating provider.

3. Beginning January 1, 2018, and each January first thereafter, the department shall publish on its website and provide in writing to each health carrier, a dollar amount for which bills for the procedure codes identified in this section shall be exempt from the dispute resolution process established in sections 376.1140 to 376.1154. Such amount shall equal the amount from the prior year, beginning with six hundred dollars in 2017, adjusted by the average of the annual average inflation rates for the medical care commodities and medical care services components of the consumer price index. In no event shall an amount exceeding one thousand two hundred dollars for a specific CPT code billed be exempt from the dispute resolution process established in sections 376.1140 to 376.1154.

376.1146. In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

(1) Whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:

(a) Fees paid to the involved physician for the same services rendered by the physician to other patients in health carrier plans in which the physician is not participating; and

(b) In the case of a dispute involving a health carrier, fees paid by the health carrier to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health carrier's plan;

(2) The level of training, education, and experience of the physician;

(3) The physician's usual charge for comparable services with regard to patients in health carrier plans in which the physician is not participating;

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

(5) Individual patient characteristics; and

(6) The usual and customary cost of the service.

376.1148. 1. When a health carrier receives a bill for emergency services from a non-participating physician, the health carrier shall pay an amount that it determines is reasonable for the emergency services rendered by the non-participating physician, except for the insured's co-payment, coinsurance, or deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating physician.

2. A non-participating physician or a health carrier may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity.

3. The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review.

4. In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health carrier's payment or the non-participating physician's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section 376.1146. If an independent dispute resolution entity determines, based on the health carrier's payment and the non-participating physician's fee, that a settlement between the health carrier and non-participating physician is reasonably likely, or that both the health carrier's payment and the non-participating physician's fee represent unreasonable extremes, the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health carrier and non-participating physician may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty-day period for dispute resolution.

5. (1) A patient who is not an insured or the patient's physician may submit a dispute regarding a fee for emergency services for review to an independent dispute resolution entity upon approval of the department.

(2) An independent dispute resolution entity shall determine a reasonable fee for the services based upon the same conditions and factors set forth in section 376.1146.

(3) A patient who is not an insured shall not be required to pay the physician's fee in order to be eligible to submit the dispute for review to an independent dispute resolution entity.

6. The determination of an independent dispute resolution entity shall be binding on the health carrier, physician, and patient, and shall be admissible in any court proceeding between the health carrier, physician, or patient, or in any administrative proceeding between this state and the physician.

376.1150. If an insured assigns benefits for a surprise bill in writing to a non-participating physician who knows the insured is insured under a health carrier, the non-participating physician shall not bill the insured except for any applicable co-payment, coinsurance, or deductible that would be owed if the insured utilized a participating physician.

376.1152. 1. If an insured assigns benefits to a non-participating physician, the health carrier shall pay the non-participating physician in accordance with subsections 2 and 3 of this section.

2. The non-participating physician may bill the health carrier for the health care services rendered, and the health carrier shall pay the non-participating physician the billed amount or attempt to negotiate reimbursement with the non-participating physician.

3. If the health carrier's attempts to negotiate reimbursement for health care services provided by a non-participating physician do not result in a resolution of the payment dispute between the non-participating physician and the health carrier, the health carrier shall pay the non-participating physician an amount the health carrier determines is reasonable for the health care services rendered, except for the insured's co-payment, coinsurance, or deductible.

4. Either the health carrier or the non-participating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity; provided that, the health carrier shall not submit the dispute unless it has complied with the requirements of subsections 1 to 3 of this section.

5. The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review.

6. In determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health carrier's payment or the non-participating physician's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section 376.1146. If an independent dispute resolution entity determines, based on the health carrier's payment and the non-participating physician's fee, that a settlement between the health carrier and non-participating physician is reasonably likely, or that both the health carrier's payment and the non-participating physician's fee represent unreasonable extremes, the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health carrier and non-participating physician may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty-day period for dispute resolution.

7. (1) An insured who does not assign benefits in accordance with subsection 1 of this section or a patient who is not an insured and who receives a surprise bill may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity.

(2) The independent dispute resolution entity shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in section 376.1146.

(3) A patient or insured who does not assign benefits in accordance with subsection 1 of this section shall not be required to pay the physician's fee to be eligible to submit the dispute for review to the independent dispute entity.

8. The determination of an independent dispute resolution entity shall be binding on the patient, physician, and health carrier, and shall be admissible in any court proceeding between the patient or insured, physician or health carrier, or in any administrative proceeding between this state and the physician.

376.1154. 1. For disputes involving an insured, if the independent dispute resolution entity determines the health carrier's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating physician. If the independent dispute resolution entity determines the non-participating physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health carrier. If a good faith negotiation directed by the independent dispute resolution entity under subsection 4 of section 376.1148 or subsection 6 of section 376.1152 results in a settlement between the health carrier and non-participating physician, the health carrier and the non-participating physician shall evenly divide and share the prorated cost for dispute resolution.

2. For disputes involving a patient who is not an insured, if the independent dispute resolution entity determines the physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient. The department shall promulgate a regulation to determine payment for the dispute resolution process in cases of hardship. If the independent dispute resolution entity determines the physician's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the physician.

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