SECOND REGULAR SESSION

SENATE BILL NO. 1057

99TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SCHUPP.

Read 1st time February 28, 2018, and ordered printed.

ADRIANE D. CROUSE, Secretary.

6718S.01I

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to unanticipated out-of-network 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 376.690, to read as follows:

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

(1) "Unanticipated out-of-network care", services received by a patient in an in-network facility from an out-of-network health care professional when the patient did not have the opportunity and ability to select such services from an in-network health care professional, or emergency services provided to a patient by an out-of-network health care professional. Unanticipated out-of-network care shall not include nonemergency services received by a patient when the patient voluntarily selects in writing an out-of-network health care professional prior to receiving care;

(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;

2. Health care professionals shall send any bill for charges incurred for unanticipated out-of-network care to the patient's health carrier. The health carrier shall pay the health care professional directly.

(1) The health carrier shall pay the health care professional the greater of the usual and customary rate for the particular health care service performed by health care professionals in the same or similar specialty and in the same geographic area, or the carrier's average in-network reimbursement for the service provided.

(2) A health care professional shall not 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 subdivision (1) of 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 ten 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 professional.

4. The director of the department of insurance, financial institutions, and professional registration shall ensure access to a mediation process when a health care professional objects to the application of the established payments described in this section. The department shall determine usual and customary rates based on benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

5. A health care professional may initiate mediation if the health care professional believes payment received for unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, and 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 time and place of services; and

(5) Other aspects of the health care professional's practice that may be relevant to the payment.

6. Health care professionals may bundle similar claims and claims presenting a common issue of fact to be resolved in a single mediation process.

7. The department of insurance, financial institutions, and professional registration may promulgate rules 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.

✓