FIRST REGULAR SESSION

SENATE BILL NO. 231

97TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR MUNZLINGER.

Read 1st time January 29, 2013, and ordered printed.

TERRY L. SPIELER, Secretary.

1236S.01I

AN ACT

To repeal section 143.790, RSMo, and to enact in lieu thereof two new sections relating to debt setoffs for unpaid healthcare expenses.

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

Section A. Section 143.790, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 143.789 and 143.790, to read as follows:

143.789. The director of the department shall have the authority to impose an offset against a refund owed to any taxpayer for the following items and in the following order of priority:

(1) Delinquent taxes owed by the taxpayer to the state of Missouri;

(2) Debts owed by such taxpayer to any state agency or support obligation owed by such taxpayer which is enforced by the division of family services on behalf of a person who is receiving support enforcement services under section 454.425;

(3) Collection assistance fees authorized under section 143.790;

(4) Eligible claims under section 143.790; and

(5) Delinquent taxes owed by the taxpayer to the United States.

143.790. 1. **[**Any hospital or health care provider who has provided health care services to an individual who was not covered by a health insurance policy or was not eligible to receive benefits under the state's medical assistance program of needy persons, Title XIX, P.L. 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301, et seq., under chapter 208, RSMo, and the health insurance for uninsured children under sections 208.631 to 208.657, RSMo, at the time such health care services were administered, and such person

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

has failed to pay for such services for a period greater than ninety days, may submit a claim to the director of the department of health and senior services for the unpaid health care services. The director of the department of health and senior services shall review such claim. If the claim appears meritorious on its face, the claim for the unpaid medical services shall constitute a debt of the department of health and senior services for purposes of sections 143.782 to 143.788, and the director may certify the debt to the department of revenue in order to set off the debtor's income tax refund. Once the debt has been certified, the director of the department of health and senior services shall submit the debt to the department of revenue under the setoff procedure established under section 143.783.

2. At the time of certification, the director of the department of health and senior services shall supply any information necessary to identify each debtor whose refund is sought to be set off pursuant to section 143.784 and certify the amount of the debt or debts owed by each such debtor.

3. If a debtor identified by the director of the department of health and senior services is determined by the department of revenue to be entitled to a refund, the department of revenue shall notify the department of health and senior services that a refund has been set off on behalf of the department of health and senior services for purposes of this section and shall certify the amount of such setoff, which shall not exceed the amount of the claimed debt certified. When the refund owed exceeds the claimed debt, the department shall send the excess amount to the debtor within a reasonable time after such excess is determined.

4. The department of revenue shall notify the debtor by certified mail the taxpayer whose refund is sought to be set off that such setoff will be made. The notice shall contain the provisions contained in subsection 3 of section 143.794, including the opportunity for a hearing to contest the setoff provided therein, and shall otherwise substantially comply with the provisions of subsection 3 of section 143.784.

5. Once a debt has been set off and finally determined under the applicable provisions of sections 143.782 to 143.788, and the department of health and senior services has received the funds transferred from the department of revenue, the department of health and senior services shall settle with each hospital or health care provider for the amounts that the department of revenue set off for such party. At the time of each settlement, each hospital or health care

provider shall be charged for administration expenses which shall not exceed twenty percent of the collected amount.

6. Lottery prize payouts made under section 313.321, RSMo, shall also be subject to the setoff procedures established in this section and any rules and regulations promulgated thereto.

7. The director of the department of revenue shall have priority to offset any delinquent tax owed to the state of Missouri. Any remaining refund shall be offset to pay a state agency debt or to meet a child support obligation that is enforced by the division of family services on behalf of a person who is receiving support enforcement services under section 454.425, RSMo.

8.**] As used in this section, the following terms shall mean:**

(1) "Appeals committee", a committee consisting of at least three people appointed by a provider to hear patient appeals of review officer rulings:

(a) That the provider has a valid claim;

(b) Regarding the amount of the claim;

(c) That a claim qualifies as an eligible claim under this section;

(2) "Collection assistance fee", a fee in the amount of fourteen dollars payable to the general fund of this state for each debt setoff being processed and an additional seventeen dollars payable to the claim clearinghouse for each debt being processed by the claim clearinghouse shall be recovered from each eligible claim to recover the costs incurred in collecting debts under this section;

(3) "Court", the supreme court, court of appeals, or any circuit court of the state, or any of their judicially or legislatively created subdivisions;

(4) "Department", the department of revenue;

(5) "Claim", a claim by a provider to receive payment of fifty dollars or more for health care services provided by such provider to a patient which has not been paid in whole or in part by the patient or third-party payer for more than one hundred sixty days after the date the provider has exhausted all available means of collecting the payment from the patient or the third-party payer, provided that in order to exhaust its available means of collecting the payment, the provider will not be required to file a legal claim against the patient or third-party payer in state or federal court;

(6) "Claim clearinghouse", the entity selected by the department

to receive and submit eligible claims on behalf of a provider in accordance with this section. The claim clearinghouse shall be selected by the department through use of and in compliance with the applicable requirements of chapter 34;

(7) "Financial hardship policy", a policy maintained by a provider to establish the circumstances in which a patient will be relieved of the obligation to pay a claim as a result of his or her financial condition. The terms of the provider's financial hardship policy shall be consistent with applicable Medicare guidelines regarding financial hardship. Each provider utilizing the claim clearinghouse to collect a claim shall maintain and utilize a financial hardship policy;

(8) "Health care services", any services that a provider renders to a patient in the course of such provider's furnishing of ambulance services to the patient. Health care services shall include, but not be limited to, treatment of patients and transporting of patients incidental or pursuant to the delivery of ambulance services by a provider or in furtherance of the purposes for which such provider is organized and licensed, provided that with respect to ground ambulance services provided by a provider that is not owned and operated by a city, county, municipality, political subdivision, governmental entity, or an entity that is exempt from federal and state income taxation, health care services shall only include those ground ambulance services provided by the provider that qualify, and emergency services as defined in section 190.100 and are provided under the terms of an agreement between the provider and a city, county, municipality, political subdivision, or a governmental entity under section 190.105;

(9) "Patient", an individual who has received health care services from a provider and who was not, at the time such health care services were provided:

(a) Eligible to receive benefits under the state's medical assistance program for needy persons under chapter 208 and the health insurance for uninsured children under sections 208.631 to 208.657; and

(b) Eligible for relief from the claim pursuant to the provider's financial hardship policy;

(10) "Provider", any provider of ambulance services licensed by the Missouri department of health and senior services in accordance with chapter 190, to include but not be limited to any provider of air

ambulance services licensed under section 190.108 and any provider of ground ambulance services licensed under section 190.109;

(11) "Refund", a patient's Missouri income tax refund which the department determines to be due under the provisions of this chapter;

(12) "Review officer", a person designated by a provider to review claims, at the request of a patient, to determine whether such provider has a valid claim, the amount of such claim, and whether such claim qualifies as an eligible claim under this section.

2. Prior to submission of a claim to the claim clearinghouse, a provider shall send written notice to a patient that such provider intends to submit a claim to the claim clearinghouse for collection by setoff under this section. The notice shall:

(1) Provide the basis for the claim;

(2) State that the provider intends to request that the department apply the patient's refund against the claim;

(3) State that a collection assistance fee will be added to the claim if it is submitted for setoff;

(4) Inform the patient of the right to contest the validity or amount of such claim by filing a request for a review with the provider; and

(5) State the time limit and procedure for requesting such review, and that failure to request a review within thirty days following receipt of the notice required under this section shall result in submission of the claim to the claim clearinghouse for setoff of the debt by the department.

3. Upon receipt of the notice required under subsection 2 of this section, any patient seeking review of a claim with the provider shall file a written request for review within thirty days of receipt of such notice. A request for a review shall be deemed filed when properly addressed and delivered to the United States Postal Service for mailing with postage prepaid. A review officer shall be appointed by the provider to review such claim. In reviewing a claim, any issue that has previously been litigated in a court proceeding shall not be considered by the review officer. If the patient seeks a review of the claim and the review officer finds either that the claim is invalid or the claim does not qualify as an eligible claim under this section, the review officer's determination shall be final and binding on the provider and such

provider shall have no right to appeal such determination. If all or part of the claim is found by the review officer to be valid and eligible for setoff under this section, the review officer shall notify the provider and the patient of such fact. Such notice shall:

(1) Inform the patient that the patient has the right to appeal the review officer's determination by filing an appeal with the appeals committee;

(2) State the time limit and procedure for requesting such an appeal; and

(3) State that failure to request the appeal within thirty days following receipt of the notice required under this subsection shall result in submission of the claim to the claim clearinghouse for setoff of the debt by the department.

4. Upon receipt of the notice required under subsection 3 of this section, any patient seeking an appeal of a determination of a review officer under this section shall file a written request for such appeal within thirty days following receipt of such notice. An appeal shall be deemed filed when properly addressed and delivered to the United States Postal Service for mailing, with postage prepaid. An appeal of a review officer's determination shall be heard by an appeals committee. In an appeal under this section, any issue that has been previously litigated in a court proceeding shall not be considered. A decision made after an appeal under this section shall determine whether a claim is owed to the provider, the amount of the claim, and whether the claim is an eligible claim under this section.

5. If the appeals committee finds a claim to be invalid or otherwise ineligible under this section, the decision of the appeals committee shall be final and binding on the provider and may not be appealed by the provider. If all or part of the claim is found by the appeals committee to be valid and eligible for setoff under this section, the appeals committee shall notify the provider and the patient of such fact. Such notice shall:

(1) Inform the patient that the patient has the right to challenge the appeals committee determination by notifying the provider that it disagrees with the determination and advising the provider as to the basis of such disagreement;

(2) State that the patient must notify the provider of the

challenge within ninety days of the patient's receipt of the notice from the appeals committee;

(3) Advise the patient that if the patient challenges the appeals committee's determination under this subsection, the provider will not be permitted to setoff the provider's claim against the patient's refund under this section, unless and until the provider files suit against the patient in court seeking a determination that the provider's claim is valid regarding the amount of the claim and that the claim is eligible for setoff under this section, and the court determines that the provider's claim is valid, the amount of the provider's claim, and that provider's claim is eligible for setoff under this section; and

(4) Advise the patient that if the patient does not challenge the appeals committee's determination under this subsection, the provider will submit the claim to the claim clearinghouse for setoff by the department under this subsection.

6. If the provider prevails in the lawsuit filed under subsection 5 of this section, the provider may submit the claim to the claim clearinghouse for setoff by the department under this section. If the patient prevails in the lawsuit filed by the provider under subsection 5 of this section, the provider shall be:

(1) Forever barred from submitting the claim to the claim clearinghouse for setoff by the department under this section;

(2) Forever barred from taking any other steps to collect the amount of the claim from the patient; and

(3) Obligated to reimburse the patient for court costs and attorney's fees associated with the lawsuit filed under subsection 5 of this section.

7. Any provider may submit a claim to the claim clearinghouse for review. In connection with its submission of a claim to the claim clearinghouse, the provider, whenever possible, shall provide the claim clearinghouse with the patient's full name, Social Security number, address, and any other identifying information that the department advises the claim clearinghouse is necessary for the department to setoff the claim under this section. The provider shall also provide the claim clearinghouse with information demonstrating the provider's compliance with the requirements of this section with respect to the claim.

8. If the claim clearinghouse receives sufficient evidence that a provider has fully complied with the requirements of this section and finds the claim valid, the claim shall be deemed eligible for setoff by the department under this section and shall be forwarded to the department. In connection with its submission of the claim to the department, the claim clearinghouse, whenever possible, shall provide the department with the patient's full name, Social Security number, address, and any other identifying information that the department advises the claim clearinghouse is necessary for the department to setoff the claim under this section.

9. If the claim clearinghouse determines that the provider has failed to comply with any applicable requirements in this section or that the claim is not valid, the claim clearinghouse shall return the claim to the provider.

10. If the department determines that a patient identified by a provider in an eligible claim filed with the department is entitled to a refund, the department shall notify the claim clearinghouse that a refund is available for setoff and the amount of such refund, and whether the refund results from a joint or combined return. Notwithstanding any provision of section 32.057 and any other confidentiality statute of this state to the contrary, the department may provide the claim clearinghouse with all information necessary to accomplish and carry out the provisions of this section and section 143.789, but shall not provide the claim clearinghouse with any information whose disclosure is prohibited by Section 6103(d) of the Internal Revenue Code of 1986, as amended. The information obtained by the claim clearinghouse from the department in accordance with this section and section 143.789 shall retain its confidentiality and shall only be used by the claim clearinghouse for the purpose described in this section and section 143.789.

11. (1) At that time, the department shall also notify the patient by regular mail that setoff against the patient's tax refund has been authorized under this section. The notice shall include the following information:

(a) The amount of the eligible claim and the name of the provider seeking setoff;

(b) That a setoff to the patient's refund against the eligible claim

has been performed; and

(c) Any amount of the refund remaining after the offset of the eligible claim.

(2) In the case of a joint or combined return, the notice shall also state the name of the nonobligated taxpayer named in the return, if any, against whom no claim is asserted, the fact that no claim is asserted against such taxpayer, and the fact that such taxpayer is entitled to receive a refund if it is due the taxpayer regardless of the claim asserted against the taxpayer's spouse. In order to obtain the refund due the taxpayer, the taxpayer shall apply in writing for an apportionment of the refund with the department within thirty days of the date of receipt of the notice unless, in anticipation of the setoff of the taxpayer's spouse's refund, such nonobligated taxpayer provided the department with a request for apportionment of the anticipated refund which was filed at the same time the original tax return was filed, in which case the department shall determine the apportionment of the refund and forward the determination of apportionment and the nonobligated taxpayer's portion of the refund to the nonobligated taxpayer within fifteen working days of the transfer of the obligated taxpayer's portion of the refund to the claim clearinghouse. Unless a request for apportionment of the anticipated refund was provided to the department as provided in this section, within ninety days after the filing of such taxpayer's application for apportionment of the refund with the department, a determination of apportionment shall be mailed to the nonobligated taxpayer by the department. The apportionment of the refund shall be final upon the expiration of thirty days from the date on which the determination of apportionment is mailed to the nonobligated taxpayer unless, within such thirty-day period, the nonobligated taxpayer applies in writing for a hearing with the department.

12. The department shall then pay to the claim clearinghouse the amount that the department has setoff for such provider, which shall include the collection assistance allocable to the claim clearinghouse. In the event the department is unable to setoff the entire eligible claim and collection assistance fee under this section, the setoff of the collection assistance fee shall have priority over the setoff of the eligible claim. If, after the department has paid to the claim

clearinghouse the amount that the department has setoff for the provider, the provider is found not to have complied with any applicable requirement of this section, the provider shall send to the patient the entire amount of the claim offset by the department for the provider plus an amount equal to the collection assistance fee.

13. In addition to refunds, lottery prize payouts made under section 313.321 shall be subject to the setoff procedures established in this section.

14. The director of the department of revenue and the director of the department of health and senior services shall promulgate rules and regulations necessary to administer 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, 2007, shall be invalid and void.

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