SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1990

94TH GENERAL ASSEMBLY

Reported from the Special Committee on Health Insurance April 7, 2008 with recommendation that House Committee Substitute for House Bill No. 1990 Do Pass. Referred to the Committee on Rules pursuant to Rule 25(21)(f).

D. ADAM CRUMBLISS, Chief Clerk

4574L.03C

AN ACT

To amend chapters 191 and 376, RSMo, by adding thereto two new sections relating to health care services.

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

Section A. Chapters 191 and 376, RSMo, are amended by adding thereto two new sections, to be known as sections 191.890 and 376.1373, to read as follows:

191.890. 1. For purposes of this section, the term "anatomic pathology services" means:

(1) "Histopathology" or "surgical pathology", the gross and microscopic examination and histologic processing of organ tissue performed by a physician or under the supervision of a physician;

(2) "Cytopathology", the examination of cells, from fluids, aspirates, washings, brushings, or smears, including the Pap test examination performed by a physician or under the supervision of a physician;

(3) "Hematology", the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician or under the supervision of a licensed physician, and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist;

(4) Subcellular pathology and molecular pathology; and

(5) Blood-banking services performed by pathologists.

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.

2. Except as provided under subsection 5 of this section, no licensed health care professional in the state shall, directly or indirectly, charge, bill, or otherwise solicit payment for anatomic pathology services unless such services were rendered personally by the licensed health care professional or under the licensed health care professional's direct supervision in accordance with Section 353 of the Public Health Service Act, 42 U.S.C. 263a.

3. No patient, insurer, third-party payor, hospital, public health clinic, or nonprofit health clinic shall be required to reimburse any licensed health care professional for charges or claims submitted in violation of this section.

4. Nothing in this section shall be construed to mandate the assignment of benefits for anatomic pathology services as defined in this section.

5. The provisions of this section do not prohibit billing of a referring laboratory for anatomic pathology services in instances where a sample or samples must be sent to another specialist, except that for purposes of this subsection, the term "referring laboratory" does not include a laboratory of a physician's office or group practice that does not perform the technical or professional component of the anatomic pathology service involved.

6. The respective state licensing boards having jurisdiction over any health care professional who may request or provide anatomic pathology services may revoke, suspend, or deny renewal of the license of any health care professional who violates the provisions of this section.

7. Nothing in this section shall be construed to prohibit a referring physician from:

(1) Sending a patient's specimen to any laboratory providing anatomic pathology services; or

(2) Communicating with a laboratory regarding the economic hardship or financial status of any patient.

8. A clinical laboratory or physician, located in this state, or in another state, providing anatomic pathology services for patients in this state, shall present or cause to be presented a claim, bill, or demand for payment for these services only to the following:

(1) The patient directly;

(2) The responsible insurer or other third-party payor;

(3) The hospital, public health clinic, or nonprofit health clinic ordering such services;

(4) The referring laboratory, other than a laboratory of a physician's office or group practice that does not perform the professional component of the anatomic pathology service;

(5) Governmental agencies or their specified public or private agent, agency, or organization on behalf of the recipient of the services.

376.1373. 1. As used in this section, the following terms shall mean:

(1) "Change in participation status", a change of a provider from an in-network provider to an out-of-network provider;

(2) "In-network provider", a provider under contract with a health carrier to provide services to enrollees at the reimbursement rates and enrollee costs associated with covered network services;

(3) "Out-of-network", a provider not under contract with a health carrier and who provides services to enrollees at the reimbursement rate and enrollee costs associated with out-of-network services;

(4) "Participating provider", an in-network provider that provides services at in-network reimbursement rates and enrollee costs;

(5) "Participation status", the contracted or otherwise agreed upon level of reimbursement that a provider may expect from the health carrier and which affects the amount of payment owed to the provider by the enrollee.

2. All health carriers shall provide notification in writing or electronically, or telephonically with the permission of the enrollee, to all enrollees if the participation status of any in-network provider changes from in-network to out-of-network. Such notice shall be delivered to enrollees at least thirty business days before the effective date of the change in the provider's participation status. At the health carrier's option and in lieu of notifying all enrollees, the health carrier may notify only enrollees who have been seen by the in-network provider whose participation status is changing in the twelve-calendar-month period immediately preceding the date of the change of the provider's participation status.

3. (1) All health carriers shall have a written procedure for ensuring continuity of care when a change in the participation status of any in-network provider occurs. Such written procedure shall be applicable regardless of the reason for the change.

(2) The procedure shall include enrollee notification of the change in the in-network provider's participation status and, if necessary, transferred to other health care providers in the provider network in a timely manner.

(3) The health carrier shall provide a copy of the procedure to the enrollee, providers, or the director upon request.

(4) The procedure shall be subject to any requirements the director may deem necessary to ensure compliance with state law.

4. If the participation status of an in-network provider changes, regardless of the reason for the change, the provision of health care services by a health carrier shall be subject to the following:

(1) The health carrier shall assure continuation of care to enrollees affected by such change for a period of up to ninety days when the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including but not limited to circumstances such as disability, pregnancy, or life-threatening illness;

(2) If continuation of care is necessary or if the health carrier failed to timely notify the enrollees as prescribed by subsection 2 of this section, an enrollee shall continue to receive services at the contracted rate and costs specified for in-network provider services, including all deductibles, coinsurance, and copayments, in the certificate of coverage or other contract between the enrollee and the health carrier. No such enrollee shall be responsible or otherwise liable for any costs incurred which exceed the in-network rates and costs associated with the provision of such services;

(3) If the in-network provider whose participation status changes to out-of-network is authorized to continue to provide services to an enrollee under this section, the health carrier shall reimburse such provider for services provided to the enrollee at the previously contracted rate for the provider when the provider was an in-network provider under the certificate of coverage or other contract between the provider and the health carrier. Such provider shall not bill or otherwise charge the enrollee for any costs other than the authorized in-network costs, such as deductibles, coinsurance, or copayments, specified in the certificate of coverage or other contract between the enrollee and the health carrier;

(4) The health carrier shall include the continuation of care requirements described in this subsection in the evidence of coverage provided to enrollees and in all provider contracts entered into, including any subcontracts and affected subcontractors;

(5) Upon request of the director, the health carrier shall provide a copy of provider contracts or subcontracts. Such contracts and subcontracts shall be subject to any requirements the director deems necessary to ensure compliance with state law.

5. The director may promulgate rules to administer and implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2008, shall be invalid and void.

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