SECOND REGULAR SESSION

HOUSE BILL NO. 2394

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES ERVIN (Sponsor), SCHAAF, FLOOK, KINGERY AND BAKER (123) (Co-sponsors).

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D. ADAM CRUMBLISS, Chief Clerk

4584L.02I

AN ACT

To amend chapter 191, RSMo, by adding thereto five new sections relating to transparency in pricing and quality of health care services, with penalty provisions.

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

Section A. Chapter 191, RSMo, is amended by adding thereto five new sections, to be known as sections 191.1000, 191.1003, 191.1005, 191.1008, and 191.1010, to read as follows:

191.1000. As used in sections 191.1000 to 191.1005, the following terms shall mean:

(1) "Estimate of cost", an estimate based on the information entered and assumptions about typical utilization and costs for medical services;

(2) "Quality of care data", data that is included in the set of quality of care indicators selected by the federal Centers for Medicare and Medicaid Services for disclosure in comparative format to the public. Quality of care data is intended to measure the quality of health care services delivered by a specific health care provider.

191.1003. 1. No patient or consumer of health care services who requests an estimate of the cost of such services prior to the provision of such services shall be required to pay for such health care services unless the consumer has in fact been provided with such estimate of costs. The provisions of this subsection shall not apply to emergency health care services.

2. Providers of health care services shall include with any estimate of costs the following: "Your estimated cost is based on the information entered and assumptions

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.

about typical utilization and costs. The actual amount billed to you may be different from the estimate of costs provided to you. Many factors affect the actual bill you will receive, and this estimate of costs does not account for all of them. Additionally, the estimate of costs is not a guarantee of insurance coverage. You will be billed at the provider's charge for any service provided to you that is not a covered benefit under your plan. Please check with your insurance company if you need help understanding your benefits for the service chosen.".

3. Nothing in this subsection shall be construed as violating any provider contract provisions with a health carrier that prohibit disclosure of the provider's fee schedule with a health carrier to third parties.

191.1005. 1. Providers of health care services shall be required to provide patients or consumers of health care services with quality of care data, including any quality of care data required to be disclosed under any provider contract entered into by such provider.

2. Failure of a health care provider to substantially comply with the quality of care data disclosure required in subsection 1 of this section shall provide a basis for licensure sanction. Any insurer or other entity that contracts with a health care provider may report a provider to the appropriate licensing board of such provider for failure to substantially comply with the quality of care data disclosure provisions under this section.

3. For purposes of this section, "insurer" includes the state of Missouri for purposes of provider contracts entered into for the rendering of health care services under a medical assistance program of the state.

4. All provider contracts entered into by a health care provider and an insurer shall include the quality of care data disclosure requirements contained in this section.

5. Programs of insurers to assess and compare the performance and efficiency of health care providers shall conform to the following requirements:

(1) If a consolidated provider performance indicator includes measures of both quality of performance and cost-efficiency, the weight given to each type of measure shall be disclosed;

(2) The relative weight of each quality of performance indicator to the overall rating shall be disclosed;

(3) Providers shall be notified at least forty-five days prior to the implementation of a quality of performance or cost-efficiency measure. The notification shall include a description of the process for using the quality of performance or cost-efficiency measure or measures;

(4) Quality of performance or cost-efficiency data shall reflect appropriate risk adjustment to account for the characteristics of the patients treated by the health care

provider. Such risk adjustment shall include, but not be limited to, case mix, severity of the medical condition, co-morbidities, and outlier episodes;

(5) When multiple providers are involved in a patient's treatment, quality of performance indicators shall disclose the methodology for determining which health care provider will be held accountable for a patient's care;

(6) In disclosing comparative data, health carriers shall prominently state that performance rankings are only a guide in choosing a health care provider and that such rankings are based on statistical analysis and as such have a risk of error;

(7) Health care providers shall have the right to review quality of performance and cost-efficiency data prior to its disclosure. If a health care provider files a timely appeal with the department of insurance, financial institutions and professional registration following such review, the health carrier shall not post the quality of performance or cost-efficiency data until the appeal is completed and the insurer prevails on appeal or the time for a provider to appeal an adverse determination by the department has elapsed. If the appeal to the department results in an adverse determination by the department for the health care provider, the provider may appeal the department's determination under the provisions of chapter 536, RSMo, within thirty days of such adverse determination by the department; and

(8) Quality of performance and cost-efficiency data shall be designed to compare like types of health care providers within the appropriate geographic market.

6. The requirement for quality of care disclosures under subsection 4 of this section or the use by insurers of programs to assess and compare the performance and efficiency of health care providers under subsection 5 of this section shall not be a basis for a provider to decline to enter into a provider contract with an insurer.

191.1008. 1. Any person who sells or otherwise distributes to the public quality of care data that is not included in the set of quality of care indicators selected by the federal Centers for Medicare and Medicaid Services for disclosure in comparative format to the public shall:

(1) Include the following disclaimer on the information distributed: "This data includes quality of care indicators other than those used by the federal Centers for Medicare and Medicaid Services and as such may be based on research methodologies that deviate from those used by such agency.";

(2) Identify what peer review process, if any, was used to confirm the validity of the data and its analysis as an objective indicator of health care quality;

(3) Indicate whether health care providers identified in the information were consulted regarding its development and data analysis standards;

(4) Provide such health care providers with the opportunity to comment on data made available to the public; and

(5) At the option of the provider, include such provider comments with the publicly disclosed information if the seller or distributor of the information declines to make changes based on such comments.

2. Articles or research studies on the topic of quality of care assessment that are published in peer-reviewed academic journals shall be exempt from the requirements of subsection 1 of this section.

3. (1) Upon receipt of a complaint of an alleged violation of this section by a person or entity other than a health carrier, the department of health and senior services shall investigate the complaint and, upon finding that a violation has occurred, shall be authorized to impose a penalty in an amount not to exceed one thousand dollars. The department shall promulgate rules governing its processes for conducting such investigations and levying fines authorized by law.

(2) 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.

191.1010. All alleged violations of sections 191.1000 to 191.1008 by a health insurer shall be investigated and enforced by the department of insurance, financial institutions and professional registration under the department's powers and responsibilities to enforce the insurance laws of this state in accordance with chapter 374, RSMo.

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