HCS HB 1990 -- HEALTH CARE SERVICES

SPONSOR: Wilson (130)

COMMITTEE ACTION: Voted "do pass" by the Special Committee on Health Insurance by a vote of 8 to 1.

This substitute changes the laws regarding health care services.

ANATOMIC PATHOLOGY SERVICES

A licensed health care professional is prohibited from charging, billing, or soliciting payment for anatomic pathology services, unless the services are rendered personally by the licensed health care professional or under his or her direct supervision. No patient, insurer, third-party payor, hospital, public health clinic, or nonprofit health clinic will be required to reimburse any licensed health care professional for charges or claims submitted in violation of this provision. Nothing will prohibit the billing of a referring laboratory for services when samples must be sent to another specialist. The state licensing board having jurisdiction over the licensed health care professional who requests or provides these services may revoke, suspend, or deny the license of anyone who violates these provisions.

HEALTH CARRIER NOTIFICATION REQUIREMENTS

All health carriers are required to notify their enrollees in writing or electronically or by phone when a health care provider changes from an in-network provider to an out-of-network provider. Carriers must notify enrollees at least 30 days prior to the effective date of the status change and must have a written procedure that ensures continuity of care for enrollees when network status changes occur including notification and transfers to other in-network providers. If a provider changes their network status, the carrier must provide enrollees with continuation of care for up to 90 days when medically necessary and medically prudent. If continuation of care is needed or if the carrier fails to notify an enrollee 30 days prior to any network status change, the enrollee can continue to receive services at in-network costs from the provider who changed to out-of-network status and the enrollee will not be liable for any charges in excess of in-network rates and costs. If the in-network provider who changed network status is authorized to provide continuation of care to an enrollee, the carrier must reimburse the provider at in-network rates.

FISCAL NOTE: No impact on General Revenue Fund in FY 2009, FY 2010, and FY 2011. Estimated Cost on Other State Funds of Unknown but Less than $100,000 in FY 2009, FY 2010, and FY 2011.

PROPONENTS: Supporters say that Medicaid and Medicare doctors cannot charge a brokerage fee for anatomic pathology services but private physicians can. The bill requires private physicians to follow the same standards of the Centers for Medicaid and Medicare Services. Disallowing a brokerage fee will protect patients from markups in charges for pathology services, and the statement for services will go directly to the patient and not to the treating physician. Thirteen states have already passed similar provisions.

Testifying for the bill were Representative Wilson (130); and Robert Breckenridge.

OPPONENTS: Those who oppose the bill say that the bill is unnecessary and is a reckless approach to rectify a situation that only some physicians identify as a problem which could be resolved in the medical community. There is no evidence of unethical behavior. The bill will put an end to the one-stop shop for patients because they will get separate bills from the physician and the pathology provider. The bill will create a monopoly for larger pathology labs and interfere with the free market. Capping the ways physicians can make money will result in fewer individuals entering the field of medicine.

Testifying against the bill were Missouri Academy of Family Physicians; Missouri Association of Osteopathic Physicians and Surgeons; and American Academy of Dermatology Association.