SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 2269

98TH GENERAL ASSEMBLY

4636H.03C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapters 197 and 376, RSMo, by adding thereto two new sections relating to health care transparency, with a delayed effective date for a certain section.

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

Section A. Chapters 197 and 376, RSMo, are amended by adding thereto two new sections, to be known as sections 197.170 and 376.1475, to read as follows:

197.170. 1. This section shall be known and may be cited as the "Health Care Cost Reduction and Transparency Act".

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

(1) "Ambulatory surgical center", as such term is defined under section 197.200;

(2) "Direct payment", as such term is defined under section 1.330;

(3) "Health care provider", the same meaning as such term is defined under section 376.1350. "Health care provider" shall also include any provider located in a Kansas border county, as defined under section 135.1670, who participates in the MO HealthNet program;

(4) "Hospital", as such term is defined under section 197.020;

(5) "Imaging center", any facility at which diagnostic imaging services are provided including, but not limited to, magnetic resonance imaging (MRI);

(6) "Medical treatment plan", a patient-specific plan of medical treatment for a particular illness, injury, or condition determined by such patient's physician, which includes the applicable current procedural terminology (CPT) code or codes.

3. Beginning July 1, 2018, ambulatory surgical centers and imaging centers shall make available to the public, in a manner that is easily understood, an estimate of the most current direct payment price information for the twenty-five most common surgical

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.

procedures or the twenty most common imaging procedures, as appropriate, performed in ambulatory surgical centers or imaging centers. Disclosure of data under this subsection shall constitute compliance with subsection 5 of this section regarding any surgical or imaging procedure for which disclosure is required under this subsection.

4. Not later than July 1, 2017, hospitals shall make available to the public, in a manner that is easily understood, the amount that would be charged without discounts for each the one hundred most prevalent diagnosis-related groups as defined by the Medicare program, Title XVIII of the Social Security Act. The diagnosis-related groups shall be described in layman's language suitable for use by reasonably informed patients. Disclosure of data under this subsection shall constitute compliance with subsection 5 of this section regarding any diagnosis-related group for which disclosure is required under this subsection.

5. Upon written request by a patient, which shall include a medical treatment plan from the patient's physician, for the direct payment cost of a particular health care service or procedure, imaging procedure, or surgery procedure, a health care provider, hospital, ambulatory surgical center, or imaging center shall provide an estimate of the direct payment price information required by this section to the patient in writing either electronically, by mail, or in person, within three business days after receiving the written request. Providing a patient a specific link to such estimated prices and making such estimated prices publicly available or posting such estimated prices on a website of the health care provider, hospital, ambulatory surgical center, or imaging center shall constitute compliance with the provisions of this subsection.

6. No health care provider shall be required to report the information required by this section if the reporting of such information reasonably could lead to the identification of the person or persons receiving health care services or procedures in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law. This section shall not apply to emergency departments, which shall comply with requirements of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd.

7. It shall be a condition of participation in the MO HealthNet program for a health care provider located in a Kansas border county, as defined under section 135.1670, to comply with the provisions of this section.

376.1475. 1. This section shall be known and may be cited as the "Predetermination of Health Care Benefits Act".

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

(1) "Administrative simplification provision", transaction and code standards promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and 45 CFR 160 and 162;

(2) "Director", the director of the department of insurance, financial institutions and professional registration;

(3) "Health benefit plan" and "health care provider", the same meanings as those terms are defined in section 376.1350;

(4) "Health care clearinghouse", the same meaning as the term is defined in 45 CFR 160.103;

(5) "Payment", a deductible or coinsurance payment and shall not include a co-payment;

(6) "Standard electronic transactions", electronic claim and remittance advice transactions created by the Accredited Standards Committee (ASC) X12 in the format of ASC X12 837I, ASC X12 837P, or ASC X12 835, or any of their respective successors.

3. Health benefit plans that receive an electronic health care predetermination request from a health care provider consistent with the requirements set forth in subsection 6 of this section shall provide the requesting health care provider with information on the amount of expected benefits coverage on the procedures specified in the request that is accurate at the time of the health benefit plan's response.

4. Any predetermination response provided by a health benefit plan under this section in good faith shall be deemed to be an estimate only and shall not be binding upon the health benefit plan with regard to the final amount of benefits actually provided by the health benefit plan.

5. The amounts for the referenced services under subsection 3 of this section shall include:

(1) The amount the patient will be expected to pay, clearly identifying any deductible amount, coinsurance, and co-payment;

(2) The amount the health care provider will be paid;

(3) The amount the institution will be paid; and

(4) Whether any payments will be reduced, but not to zero dollars, or increased from the agreed fee schedule amounts, and if so, the health care policy that identifies why the payments will be reduced or increased.

6. The health care predetermination request and predetermination response shall be conducted in accordance with administrative simplification provisions using the currently applicable standard electronic transactions, without regard to whether the transaction is mandated by HIPAA. It shall also comply with any rules promulgated by

the director, without regard to whether such rules are mandated by HIPAA. To the extent HIPAA-mandated electronic claim and remittance transactions are modified to include predetermination, the provisions of this section shall not apply to health benefit plans which provide this information under HIPAA.

7. The health benefit plan's predetermination response to the health care predetermination request shall be returned using the same transmission method as that of the request. This shall include a real time response for a real time request.

8. A health care clearinghouse that contracts with a health care provider shall be required to conduct a transaction as described in subsections 5, 6, and 7 of this section if requested by the health care provider.

9. Nothing in this act precludes the collection of payment prior to receiving health benefit services once a health benefit plan has fulfilled any predetermination request.

10. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months or less duration, or any other supplemental policy.

11. The director shall adopt rules and regulations necessary to carry out the provisions of this section.

12. 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, 2016, shall be invalid and void.

Section B. Section 376.1475 of Section A of this act shall become effective July 1, 2018.

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