House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Committee Substitute for House Bill No. 1870, Page 2, Section 197.180, Line 23, by inserting after all of said line the following:

"376.427. 1. As used in this section, the following terms mean:

(1) "Health care services", medical, surgical, dental, podiatric, pharmaceutical, chiropractic, licensed ambulance service, and optometric services;

(2) "Insured", any person entitled to benefits under a contract of accident and sickness insurance, or medical-payment insurance issued as a supplement to liability insurance but not including any other coverages contained in a liability or a workers' compensation policy, issued by an insurer;

(3) "Insurer", any person, reciprocal exchange, interinsurer, fraternal benefit society, health services corporation, self-insured group arrangement to the extent not prohibited by federal law, or any other legal entity engaged in the business of insurance;

(4) "Provider", a physician, hospital, dentist, podiatrist, chiropractor, pharmacy, licensed ambulance service, or optometrist, licensed by this state.

2. Upon receipt of an assignment of benefits made by the insured to a provider, the insurer shall issue the instrument of payment for a claim for payment for health care services in the name of the provider. All claims shall be paid within thirty days of the receipt by the insurer of all documents reasonably needed to determine the claim.

3. Nothing in this section shall preclude an insurer from voluntarily issuing an instrument of payment in the single name of the provider.

4. Except as provided in subsection 5 of this section, this section shall not require any insurer, health services corporation, health maintenance corporation or preferred provider organization which directly contracts with certain members of a class of providers for the delivery of health care services to issue payment as provided pursuant to this section to those members of the class which do not have a contract with the insurer.

5. Payment for all services shall be made directly to the providers when the carrier has authorized the patient to seek such services from a provider outside the carrier's network.

6. Notwithstanding any other provision of the law to the contrary, the provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state.

376.1367. When conducting utilization review or making a benefit determination for emergency services:

(1) For purposes of this section the term, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such

Action Taken_____ Date _____

that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act;

(2) A health carrier shall cover emergency services necessary to screen and stabilize an enrollee, who presents with an emergency medical condition as determined by the treating emergency department physician, and shall not require prior authorization of such services;

[~~(2)~~**]** (3) Before a health carrier denies payment for an emergency service, it shall review the enrollee's medical record regarding the emergency medical condition at issue. This review shall be completed by a board certified physician who has practiced in emergency medicine and is actively practicing as a physician licensed under chapter 334. A health carrier shall use a reasonable prudent layperson standard for determining whether there was an emergency medical condition as set forth in subdivision (1) of this section and shall not deny payment for an emergency service based predominantly on current procedural terminology or international classification of diseases (ICD) codes;

(4) Coverage of emergency services shall be subject to applicable co-payments, coinsurance and deductibles;

[~~(3)~~**]** (5) When an enrollee receives an emergency service that requires immediate post evaluation or post stabilization services, a health carrier shall provide an authorization decision within sixty minutes of receiving a request; if the authorization decision is not made within **[**~~thirty~~**]** sixty minutes, such services shall be deemed approved;

(6) Payment for all services covered under this section shall be paid directly to the health care provider by the health carrier regardless of whether the provider is a participating provider;

(7) Notwithstanding any other provision of the law to the contrary, the provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.