SS SB 982 -- PAYMENTS FOR HEALTH CARE SERVICES

SPONSOR: Wieland (Henderson)

COMMITTEE ACTION: Voted "Do Pass" by the Standing Committee on Children and Families by a vote of 9 to 0. Voted "Do Pass" by the Standing Committee on Rules- Legislative Oversight by a vote of 11 to 0.

This bill modifies provisions relating to payments for health care services.

DIRECT PAYMENT FOR AUTHORIZED SERVICES

This bill provides that when a health benefit plan does not provide for payment to out-of-network providers for all or most services that are covered if provided in-network, including HMO plans and exclusive provider organization (EPO) plans, payment for all services shall be made directly to the health care providers when the health carrier has authorized for such services to be received from an out-of-network provider (Section 376.427, RSMo).

UNANTICIPATED OUT-OF-NETWORK CARE

Health care professionals shall send any U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, for charges incurred for unanticipated out-of-network care to the patient's health carrier. The bill specifies that health carriers shall pay health care professionals a reasonable rate for unanticipated out-of-network care, requires carriers and health care professionals to negotiate in good faith to attempt to determine a reimbursement amount if the health care professional declines the carrier's initial offer, provides for disputes to be resolved through a binding arbitration process, and prohibits health care professionals from billing patients for any difference between the payment received and the payment that would have been received based on the rate charged by that professional.

When unanticipated out-of-network care is provided, the health care professional may bill the patient for no more than the cost-sharing requirements that would be applicable if the services had been provided by an in-network professional. For purposes of enrollees' deductible and out-of-pocket maximum, these payments shall be treated as though they were paid to an in-network professional.

The Director of the Department of Insurance, Financial Institutions and Professional Registration shall provide for a binding arbitration process when a health care professional and health carrier cannot agree to a reasonable reimbursement rate. The

arbitrator shall determine a reimbursement rate between 120% of the Medicare allowed amount and the 70th percentile of the usual and customary rate based on benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

The bill specifies information that the arbitrator shall consider in rendering his or her decision, requires the parties to execute a nondisclosure agreement prior to the arbitration, and specifies that the parties shall share the arbitration costs equally (Section 376.690).

These provisions shall take effect on January 1, 2019.

These provisions are similar to SB 1057 and SCS SB 928 (2018).

DENTAL SERVICES

This amendment requires health carriers and other entities contracting for the delivery of dental services to update their website at least once per month with any changes to their provider network. Upon notification by an enrollee, these provisions require health carriers and contracting entities to reprocess out-of-network claims as in-network where the enrollee was not notified as specified in the bill before the services were provided (Section 376.1063).

These provisions are similar to SB 852 (2018).

EMERGENCY MEDICAL CONDITIONS

This bill specifies that whether an ailment is considered an "emergency medical condition" depends on the person having sufficiently severe symptoms, regardless of what final diagnosis is given (Section 376.1350).

The bill specifies that necessity of emergency services to screen and stabilize a patient shall be determined by the treating health care provider.

Before a health carrier denies payment for an emergency service based on the lack of an emergency medical condition, it shall review the enrollee's medical records regarding the emergency condition at issue. If a health carrier requests records for a potential denial, the provider shall submit the record to the carrier within 45 days or the claim shall be subject to the prompt payment insurance law. The carrier's review of the records shall be completed by a board certified physician licensed to practice in the state.

This bill increases, from 30 to 60 minutes, the amount of time health carriers have to provide authorization decisions for immediate post evaluation or post stabilization services before the services are deemed approved.

When a patient's health benefit plan does not provide for payment to out-of-network healthcare providers for emergency services, including but not limited to HMO and EPO plans, payment for all emergency services necessary to screen and stabilize the enrollee shall be paid directly to the health care provider by the health carrier. Any service authorized by the health carrier for the enrollee once the enrollee is stabilized shall also be paid by the health carrier directly to the provider (Section 376.1367).

These provisions are similar to SCS SB 928 and SB 1057 (2018).

PROPONENTS: Supporters say that this bill will protect consumers from billing disputes between doctors and insurance companies by addressing how to handle claims and clarifying on the standard insurers should use.

Testifying for the bill were Senator Wieland; American Heart Association; Shawn D'aloer, Missouri Health Care for All; BJC Healthcare; Cox Health; SSM Health; Missouri Society of Anesthesiologist; Center for Diagnostic Imaging; Washington University; Missouri College of Emery Physicians; Missouri Hospital Association; College of American Pathologists; St Luke's Health System; St Louis Area Business Health Coalition; Missouri Insurance Coalition; and the Missouri State Medical Association.

OPPONENTS: Those who oppose the bill say that it will have an adverse impact on ambulance districts and licensed ambulance service should be removed from the bill.

Testifying against the bill was Frank Foster, Rural Ambulance Districts.