SS SB 982 -- PAYMENTS FOR HEALTH CARE SERVICES

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

FEE REQUIREMENTS FOR INSURANCE COMPANIES

This bill modifies the fee requirements for every individual or entity making a filing with the Department of Insurance, Financial Institutions and Professional Registration. These fees will be deposited in the State Treasury to the credit of the Insurance Dedicated Fund (Sections 354.150, 354.495, 374.150, and 374.230, RSMo).

ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE

This bill provides that the Director of the Department of Insurance, Financial Institutions and Professional Registration shall determine that a managed care plan's network is adequate if the managed care plan is being offered by a health carrier accredited by the Accreditation Association for Ambulatory Health Care (Section 354.603).

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).

UNANTICIPATED OUT-OF-NETWORK CARE

The bill specifies that 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 within 45 processing days. Health carriers shall pay health care professionals a reasonable rate for unanticipated out-of-network care; if the health care professional participates in the health carrier's commercial networks, the offer of reimbursement shall be the amount from the network with the highest reimbursement rate.

The bill requires carriers and health care professionals to negotiate within 60 days, in good faith to determine a reimbursement amount. If the health care professional declines the carrier's initial offer, the bill provides for disputes to be

resolved through a binding arbitration process as outlined, 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 as described. The in-network deductible and out-of-pocket maximum, cost sharing requirements shall apply to the claim for the unanticipated out-of-network care.

The Director of the Department of Insurance, Financial Institutions, and Professional Registration shall randomly select an arbitrator from the department's approved list and 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 certain information 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.

This bill requires any health carrier engaged in the act of contracting with providers for the delivery of dental services, or in the act of selling or assigning dental network plans, to update their electronic and paper provider materials made available to plan members or other potential plan members upon receiving written notice of changes by providers.

The Department of Insurance, Financial Institutions, and Professional Registration shall consider violations of the bill when conducting a market conduct examination (Section 376.690). These provisions shall take effect on January 1, 2019.

ELECTRONIC AND PAPER DENTAL SERVICES PROVIDER MATERIALS

This bill requires any health carrier engaged in the act of contracting with providers for the delivery of dental services, or in the act of selling or assigning dental network plans, to update their electronic and paper provided materials made available to plan members or other potential plan members upon receiving written notice of changes by providers.

The Department of Insurance, Financial Institutions and Professional Registration shall consider violations when conducting a market conduct examination (Section 376.1065).

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(12)).

This bill specifies that necessity of emergency services to screen and stabilize a patient shall be determined by the treating health care provider (Section 376.1367(1)).

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 (Section 376.1367(3)).

The bill increases, from 30 minutes 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 (Section 376.1367(4)).

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(5)).

ELECTRONIC NOTIFICATION OF PORTABLE ELECTRONICS INSURANCE INFORMATION

This bill requires that an agreement to receive notices and correspondence by electronic means for portable electronics insurance information be done in accordance with Section 432.220 regarding the Uniform Electronic Transactions Act.