FIRST REGULAR SESSION

# HOUSE BILL NO. 492

## 100TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE HENDERSON.

1195H.01I DANA RADEMAN MILLER, Chief Clerk

## AN ACT

To repeal section 376.1350, RSMo, and to enact in lieu thereof two new sections relating to health carrier reimbursements, with penalty provisions.

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

Section A. Section 376.1350, RSMo, is repealed and two new sections enacted in lieu
2 thereof, to be known as sections 376.772 and 376.1350, to read as follows:

**376.772. 1. For purposes of sections 376.772 and 376.1350, the following terms**
2 **mean:**
3 **(1) "Credit card payment", a type of electronic funds transfer in which a health**
4 **carrier, as defined in section 376.1350, or any entity acting on behalf of the health carrier,**
5 **issues a single-use series of numbers associated with the payment of health care services,**
6 **as defined in section 376.1350, performed by a health care provider, as defined in section**
7 **376.1350, and chargeable to a predetermined dollar amount, whereby the health care**
8 **provider is responsible for processing the payment using a credit card terminal or internet**
9 **portal. Such term shall include virtual or online credit card payments, whereby no**
10 **physical credit card is presented to the health care provider and the single-use credit card**
11 **expires upon payment processing;**
12 **(2) "Electronic funds transfer", a transaction that takes place over a computerized**
13 **network, either among accounts at the same financial institution or to or through different**
14 **accounts at separate financial institutions.**
15 **2. No health carrier, nor any entity acting on their behalf, shall restrict methods of**
16 **reimbursements to a health care provider for health care services to any reimbursement**
17 **method, such as a credit card payment, which requires the health care provider to pay a**

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.

18 **fee, discount the amount of their claim for reimbursement, or remit any other form of**
19 **remuneration in order to redeem the amount of their claim for reimbursement.**
20 **3. If a health carrier is initiating a reimbursement method or changing the**
21 **reimbursement method to a health care provider, a health carrier or entity acting on its**
22 **behalf shall:**
23 **(1) Notify the health care provider if any fee, discount, or other remuneration is**
24 **required to redeem the reimbursement amount; and**
25 **(2) For any contract renewed or entered into after August 28, 2019, allow the**
26 **provider to select an alternative reimbursement method which has no fee, discount or other**
27 **form of remuneration necessary to redeem the reimbursement amount, and such**
28 **alternative reimbursement method shall be used to reimburse the health care provider**
29 **until the health care provider informs the health carrier otherwise.**
30 **4. For any contract renewed or entered into after August 28, 2019, the provisions**
31 **of this section shall not be waived by contract, and any contractual clause in conflict with**
32 **the provisions of this section or that purports to waive any requirements of this section is**
33 **void.**
34 **5. The provisions of sections 375.930 to 375.938 shall apply to any violations of this**
35 **section.**

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:
2 (1) "Adverse determination", a determination by a health carrier or its designee
3 utilization review organization that an admission, availability of care, continued stay or other
4 health care service has been reviewed and, based upon the information provided, does not meet
5 the health carrier's requirements for medical necessity, appropriateness, health care setting, level
6 of care or effectiveness, and the payment for the requested service is therefore denied, reduced
7 or terminated;
8 (2) "Ambulatory review", utilization review of health care services performed or
9 provided in an outpatient setting;
10 (3) "Case management", a coordinated set of activities conducted for individual patient
11 management of serious, complicated, protracted or other health conditions;
12 (4) "Certification", a determination by a health carrier or its designee utilization review
13 organization that an admission, availability of care, continued stay or other health care service
14 has been reviewed and, based on the information provided, satisfies the health carrier's
15 requirements for medical necessity, appropriateness, health care setting, level of care and
16 effectiveness;

17 (5) "Clinical peer", a physician or other health care professional who holds a
18 nonrestricted license in a state of the United States and in the same or similar specialty as
19 typically manages the medical condition, procedure or treatment under review;
20 (6) "Clinical review criteria", the written screening procedures, decision abstracts,
21 clinical protocols and practice guidelines used by the health carrier to determine the necessity
22 and appropriateness of health care services;
23 (7) "Concurrent review", utilization review conducted during a patient's hospital stay or
24 course of treatment;
25 (8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under
26 the terms of a health benefit plan;
27 (9) **"Credit card payment", a type of electronic funds transfer in which a health**
28 **carrier, or any entity acting on behalf of the health carrier, issues a single-use series of**
29 **numbers associated with the payment of health care services performed by a health care**
30 **provider and chargeable to a predetermined dollar amount, whereby the health care**
31 **provider is responsible for processing the payment using a credit card terminal or internet**
32 **portal. Such term shall include virtual or online credit card payments, whereby no**
33 **physical credit card is presented to the health care provider and the single-use credit card**
34 **expires upon payment processing;**
35 **(10)** "Director", the director of the department of insurance, financial institutions and
36 professional registration;
37 **[**~~(10)~~**] (11)** "Discharge planning", the formal process for determining, prior to discharge
38 from a facility, the coordination and management of the care that a patient receives following
39 discharge from a facility;
40 **[**~~(11)~~**] (12)** "Drug", any substance prescribed by a licensed health care provider acting
41 within the scope of the provider's license and that is intended for use in the diagnosis, mitigation,
42 treatment or prevention of disease. The term includes only those substances that are approved
43 by the FDA for at least one indication;
44 **(13) "Electronic funds transfer", a transaction that takes place over a computerized**
45 **network, either among accounts at the same financial institution or to or through different**
46 **accounts at separate financial institutions;**
47 **[**~~(12)~~**] (14)** "Emergency medical condition", the sudden and, at the time, unexpected
48 onset of a health condition that manifests itself by symptoms of sufficient severity, regardless of
49 the final diagnosis that is given, that would lead a prudent lay person, possessing an average
50 knowledge of medicine and health, to believe that immediate medical care is required, which
51 may include, but shall not be limited to:
52 (a) Placing the person's health in significant jeopardy;

53 (b) Serious impairment to a bodily function;
54 (c) Serious dysfunction of any bodily organ or part;
55 (d) Inadequately controlled pain; or
56 (e) With respect to a pregnant woman who is having contractions:
57 a. That there is inadequate time to effect a safe transfer to another hospital before
58 delivery; or
59 b. That transfer to another hospital may pose a threat to the health or safety of the woman
60 or unborn child;
61 **[**~~(13)~~**] (15)** "Emergency service", a health care item or service furnished or required to
62 evaluate and treat an emergency medical condition, which may include, but shall not be limited
63 to, health care services that are provided in a licensed hospital's emergency facility by an
64 appropriate provider;
65 **[**~~(14)~~**] (16)** "Enrollee", a policyholder, subscriber, covered person or other individual
66 participating in a health benefit plan;
67 **[**~~(15)~~**] (17)** "FDA", the federal Food and Drug Administration;
68 **[**~~(16)~~**] (18)** "Facility", an institution providing health care services or a health care
69 setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory
70 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
71 laboratory and imaging centers, and rehabilitation and other therapeutic health settings;
72 **[**~~(17)~~**] (19)** "Grievance", a written complaint submitted by or on behalf of an enrollee
73 regarding the:
74 (a) Availability, delivery or quality of health care services, including a complaint
75 regarding an adverse determination made pursuant to utilization review;
76 (b) Claims payment, handling or reimbursement for health care services; or
77 (c) Matters pertaining to the contractual relationship between an enrollee and a health
78 carrier;
79 **[**~~(18)~~**] (20)** "Health benefit plan", a policy, contract, certificate or agreement entered into,
80 offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of
81 the costs of health care services; except that, health benefit plan shall not include any coverage
82 pursuant to liability insurance policy, workers' compensation insurance policy, or medical
83 payments insurance issued as a supplement to a liability policy;
84 **[**~~(19)~~**] (21)** "Health care professional", a physician or other health care practitioner
85 licensed, accredited or certified by the state of Missouri to perform specified health services
86 consistent with state law;
87 **[**~~(20)~~**] (22)** "Health care provider" or "provider", a health care professional or a facility;

88 **[**~~(21)~~**] (23)** "Health care service", a service for the diagnosis, prevention, treatment, cure
89 or relief of a health condition, illness, injury or disease;
90 **[**~~(22)~~**] (24)** "Health carrier", an entity subject to the insurance laws and regulations of this
91 state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any
92 of the costs of health care services, including a sickness and accident insurance company, a
93 health maintenance organization, a nonprofit hospital and health service corporation, or any other
94 entity providing a plan of health insurance, health benefits or health services; except that such
95 plan shall not include any coverage pursuant to a liability insurance policy, workers'
96 compensation insurance policy, or medical payments insurance issued as a supplement to a
97 liability policy;
98 **[**~~(23)~~**] (25)** "Health indemnity plan", a health benefit plan that is not a managed care plan;
99 **[**~~(24)~~**] (26)** "Managed care plan", a health benefit plan that either requires an enrollee to
100 use, or creates incentives, including financial incentives, for an enrollee to use, health care
101 providers managed, owned, under contract with or employed by the health carrier;
102 **[**~~(25)~~**] (27)** "Participating provider", a provider who, under a contract with the health
103 carrier or with its contractor or subcontractor, has agreed to provide health care services to
104 enrollees with an expectation of receiving payment, other than coinsurance, co-payments or
105 deductibles, directly or indirectly from the health carrier;
106 **[**~~(26)~~**] (28)** "Peer-reviewed medical literature", a published scientific study in a journal
107 or other publication in which original manuscripts have been published only after having been
108 critically reviewed for scientific accuracy, validity and reliability by unbiased independent
109 experts, and that has been determined by the International Committee of Medical Journal Editors
110 to have met the uniform requirements for manuscripts submitted to biomedical journals or is
111 published in a journal specified by the United States Department of Health and Human Services
112 pursuant to Section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable
113 peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications
114 or supplements to publications that are sponsored to a significant extent by a pharmaceutical
115 manufacturing company or health carrier;
116 **[**~~(27)~~**] (29)** "Person", an individual, a corporation, a partnership, an association, a joint
117 venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any
118 combination of the foregoing;
119 **[**~~(28)~~**] (30)** "Prospective review", utilization review conducted prior to an admission or
120 a course of treatment;
121 **[**~~(29)~~**] (31)** "Retrospective review", utilization review of medical necessity that is
122 conducted after services have been provided to a patient, but does not include the review of a

123 claim that is limited to an evaluation of reimbursement levels, veracity of documentation,
124 accuracy of coding or adjudication for payment;

125 **[**~~(30)~~**] (32)** "Second opinion", an opportunity or requirement to obtain a clinical
126 evaluation by a provider other than the one originally making a recommendation for a proposed
127 health service to assess the clinical necessity and appropriateness of the initial proposed health
128 service;

129 **[**~~(31)~~**] (33)** "Stabilize", with respect to an emergency medical condition, that no material
130 deterioration of the condition is likely to result or occur before an individual may be transferred;

131 **[**~~(32)~~**] (34)** "Standard reference compendia":

132 (a) The American Hospital Formulary Service-Drug Information; or

133 (b) The United States Pharmacopoeia-Drug Information;

134 **[**~~(33)~~**] (35)** "Utilization review", a set of formal techniques designed to monitor the use
135 of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care
136 services, procedures, or settings. Techniques may include ambulatory review, prospective
137 review, second opinion, certification, concurrent review, case management, discharge planning
138 or retrospective review. Utilization review shall not include elective requests for clarification
139 of coverage;

140 **[**~~(34)~~**] (36)** "Utilization review organization", a utilization review agent as defined in
141 section 374.500.

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