FIRST REGULAR SESSION

[P E R F E C T E D**]**

SENATE BILL NO. 103

100TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SCHUPP.

Pre-filed December 1, 2018, and ordered printed.

Read 2nd time January 23, 2019, and referred to the Committee on Insurance and Banking.

Reported from the Committee February 7, 2019, with recommendation that the bill do pass and be placed on the Consent Calendar.

Taken up March 26, 2019. Read 3rd time and placed upon its final passage; bill passed.

ADRIANE D. CROUSE, Secretary.

0504S.01P

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AN ACT

To repeal section 376.690, RSMo, and to enact in lieu thereof one new section relating to unanticipated out-of-network health care services.

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

Section A. Section 376.690, RSMo, is repealed and one new section
2 enacted in lieu thereof, to be known as section 376.690, to read as follows:

376.690. 1. As used in this section, the following terms shall mean:
2 (1) "Emergency medical condition", the same meaning given to such term
3 in section 376.1350;
4 (2) "Facility", the same meaning given to such term in section 376.1350;
5 (3) "Health care professional", the same meaning given to such term in
6 section 376.1350;
7 (4) "Health carrier", the same meaning given to such term in section
8 376.1350;
9 (5) "Unanticipated out-of-network care", health care services received by
10 a patient in an in-network facility from an out-of-network health care professional
11 from the time the patient presents with an emergency medical condition until the
12 time the patient is discharged.
13 2. (1) Health care professionals **[**may**]** **shall** send any claim for charges
14 incurred for unanticipated out-of-network care to the patient's health carrier
15 within one hundred eighty days of the delivery of the unanticipated
16 out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

17 1500, or its successor form, or electronically using the 837 HIPAA format, or its
18 successor.

19 (2) Within forty-five processing days, as defined in section 376.383, of
20 receiving the health care professional's claim, the health carrier shall offer to pay
21 the health care professional a reasonable reimbursement for unanticipated
22 out-of-network care based on the health care professional's services. If the health
23 care professional participates in one or more of the carrier's commercial networks,
24 the offer of reimbursement for unanticipated out-of-network care shall be the
25 amount from the network which has the highest reimbursement.

26 (3) If the health care professional declines the health carrier's initial offer
27 of reimbursement, the health carrier and health care professional shall have sixty
28 days from the date of the initial offer of reimbursement to negotiate in good faith
29 to attempt to determine the reimbursement for the unanticipated out-of-network
30 care.

31 (4) If the health carrier and health care professional do not agree to a
32 reimbursement amount by the end of the sixty-day negotiation period, the dispute
33 shall be resolved through an arbitration process as specified in subsection 4 of
34 this section.

35 (5) To initiate arbitration proceedings, either the health carrier or health
36 care professional must provide written notification to the director and the other
37 party within one hundred twenty days of the end of the negotiation period,
38 indicating their intent to arbitrate the matter and notifying the director of the
39 billed amount and the date and amount of the final offer by each party. A claim
40 for unanticipated out-of-network care may be resolved between the parties at any
41 point prior to the commencement of the arbitration proceedings. Claims may be
42 combined for purposes of arbitration, but only to the extent the claims represent
43 similar circumstances and services provided by the same health care professional,
44 and the parties attempted to resolve the dispute in accordance with subdivisions
45 (3) to (5) of this subsection.

46 (6) No health care professional who sends a claim to a health carrier
47 under subsection 2 of this section shall send a bill to the patient for any
48 difference between the reimbursement rate as determined under this subsection
49 and the health care professional's billed charge.

50 3. (1) When unanticipated out-of-network care is provided, the health
51 care professional who sends a claim to a health carrier under subsection 2 of this
52 section may bill a patient for no more than the cost-sharing requirements

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53 described under this section.
54 (2) Cost-sharing requirements shall be based on the reimbursement
55 amount as determined under subsection 2 of this section.
56 (3) The patient's health carrier shall inform the health care professional
57 of its enrollee's cost-sharing requirements within forty-five processing days of
58 receiving a claim from the health care professional for services provided.
59 (4) The in-network deductible and out-of-pocket maximum cost-sharing
60 requirements shall apply to the claim for the unanticipated out-of-network care.
61 4. The director shall ensure access to an external arbitration process when
62 a health care professional and health carrier cannot agree to a reimbursement
63 under subdivision (3) of subsection 2 of this section. In order to ensure access,
64 when notified of a parties' intent to arbitrate, the director shall randomly select
65 an arbitrator for each case from the department's approved list of arbitrators or
66 entities that provide binding arbitration. The director shall specify the criteria
67 for an approved arbitrator or entity by rule. The costs of arbitration shall be
68 shared equally between and will be directly billed to the health care professional
69 and health carrier. These costs will include, but are not limited to, reasonable
70 time necessary for the arbitrator to review materials in preparation for the
71 arbitration, travel expenses and reasonable time following the arbitration for
72 drafting of the final decision.
73 5. At the conclusion of such arbitration process, the arbitrator shall issue
74 a final decision, which shall be binding on all parties. The arbitrator shall
75 provide a copy of the final decision to the director. The initial request for
76 arbitration, all correspondence and documents received by the department and
77 the final arbitration decision shall be considered a closed record under section
78 374.071. However, the director may release aggregated summary data regarding
79 the arbitration process. The decision of the arbitrator shall not be considered an
80 agency decision nor shall it be considered a contested case within the meaning of
81 section 536.010.
82 6. The arbitrator shall determine a dollar amount due under subsection
83 2 of this section between one hundred twenty percent of the Medicare-allowed
84 amount and the seventieth percentile of the usual and customary rate for the
85 unanticipated out-of-network care, as determined by benchmarks from
86 independent nonprofit organizations that are not affiliated with insurance
87 carriers or provider organizations.
88 7. When determining a reasonable reimbursement rate, the arbitrator

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89 shall consider the following factors if the health care professional believes the
90 payment offered for the unanticipated out-of-network care does not properly
91 recognize:
92 (1) The health care professional's training, education, or experience;
93 (2) The nature of the service provided;
94 (3) The health care professional's usual charge for comparable services
95 provided;
96 (4) The circumstances and complexity of the particular case, including the
97 time and place the services were provided; and
98 (5) The average contracted rate for comparable services provided in the
99 same geographic area.
100 8. The enrollee shall not be required to participate in the arbitration
101 process. The health care professional and health carrier shall execute a
102 nondisclosure agreement prior to engaging in an arbitration under this section.
103 9. **[**This section shall take effect on January 1, 2019.
104 10.**]** The department of insurance, financial institutions and professional
105 registration may promulgate rules and fees as necessary to implement the
106 provisions of this section, including but not limited to procedural requirements
107 for arbitration. Any rule or portion of a rule, as that term is defined in section
108 536.010, that is created under the authority delegated in this section shall
109 become effective only if it complies with and is subject to all of the provisions of
110 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
111 nonseverable and if any of the powers vested with the general assembly pursuant
112 to chapter 536 to review, to delay the effective date, or to disapprove and annul
113 a rule are subsequently held unconstitutional, then the grant of rulemaking
114 authority and any rule proposed or adopted after August 28, 2018, shall be
115 invalid and void.

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