SECOND REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED]

SENATE SUBSTITUTE FOR

SENATE BILL NO. 982

99TH GENERAL ASSEMBLY

2018

6265S.09T

Unofficial Bill Copy

AN ACT

To repeal sections 354.150, 354.495, 354.603, 374.115, 374.150, 374.230, 376.427, 376.1350, 376.1367, and 379.1545, RSMo, and to enact in lieu thereof eleven new sections relating to payments for health care services, with an effective date for certain sections.

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

Section A. Sections 354.150, 354.495, 354.603, 374.115, 374.150, 374.230,
2 376.427, 376.1350, 376.1367, and 379.1545, RSMo, are repealed and eleven new
3 sections enacted in lieu thereof, to be known as sections 354.150, 354.495,
4 354.603, 374.150, 374.230, 376.427, 376.690, 376.1065, 376.1350, 376.1367, and
5 379.1545, to read as follows:

354.150. 1. Every health services corporation subject to the provisions of
2 sections 354.010 to 354.380 shall pay **[**the following fees**]** to the director **[**for the
3 administration and enforcement of the provisions of this chapter:
4 (1) For filing the declaration required on organization of each domestic
5 company, two hundred fifty dollars;
6 (2) For filing statement and certified copy of charter required of foreign
7 companies, two hundred fifty dollars;
8 (3) For filing application to renew certificate of authority, along with all
9 required annual reports, including the annual statement, actuarial statement,
10 risk-based capital report, report of valuation of policies or other obligations of
11 assurance, and audited financial report of any company doing business in this
12 state, one thousand five hundred dollars;
13 (4) For filing any paper, document, or report not filed under subdivision

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

14 (1), (2), or (3) of this section but required to be filed in the office of the director,
15 fifty dollars each;
16 (5) For affixing the seal of office of the director, ten dollars;
17 (6) For accepting each service of process upon the company, ten dollars]
18 **the fees specified in section 374.230**.
19 2. Fees mandated in subdivision (1) of [subsection 1 of this section]
20 **section 374.230** shall be waived if a majority shareholder, officer, or director of
21 the organizing corporation is a member of the Missouri National Guard or any
22 other active duty military, resides in the state of Missouri, and provides proof of
23 such service to the secretary of state.

354.495. Every health maintenance organization subject to sections
2 354.400 to 354.636 shall pay to the director the [following fees:
3 (1) For filing the declaration required on organization of each domestic
4 company, two hundred fifty dollars;
5 (2) For filing statement and certified copy of charter required of foreign
6 companies, two hundred fifty dollars;
7 (3) For filing application to renew certificate of authority, along with all
8 required annual reports, including the annual statement, actuarial statement,
9 risk based capital report, report of valuation of policies or other obligations of
10 assurance, and audited financial report of any company doing business in this
11 state, one thousand five hundred dollars;
12 (4) For filing any paper, document, or report not filed under subdivision
13 (1), (2), or (3) of this section but required to be filed in the office of the director,
14 fifty dollars each;
15 (5) For affixing the seal of office of the director, ten dollars;
16 (6) For accepting each service of process upon the company, ten dollars]
17 **fees specified in section 374.230**.

354.603. 1. A health carrier shall maintain a network that is sufficient
2 in number and types of providers to assure that all services to enrollees shall be
3 accessible without unreasonable delay. In the case of emergency services,
4 enrollees shall have access twenty-four hours per day, seven days per week. The
5 health carrier's medical director shall be responsible for the sufficiency and
6 supervision of the health carrier's network. Sufficiency shall be determined by
7 the director in accordance with the requirements of this section and by reference
8 to any reasonable criteria, including but not limited to provider-enrollee ratios by
9 specialty, primary care provider-enrollee ratios, geographic accessibility,

Unofficial Bill Copy

10 reasonable distance accessibility criteria for pharmacy and other services, waiting
11 times for appointments with participating providers, hours of operation, and the
12 volume of technological and specialty services available to serve the needs of
13 enrollees requiring technologically advanced or specialty care.

14 (1) In any case where the health carrier has an insufficient number or
15 type of participating providers to provide a covered benefit, the health carrier
16 shall ensure that the enrollee obtains the covered benefit at no greater cost than
17 if the benefit was obtained from a participating provider, or shall make other
18 arrangements acceptable to the director.

19 (2) The health carrier shall establish and maintain adequate
20 arrangements to ensure reasonable proximity of participating providers, including
21 local pharmacists, to the business or personal residence of enrollees. In
22 determining whether a health carrier has complied with this provision, the
23 director shall give due consideration to the relative availability of health care
24 providers in the service area under, especially rural areas, consideration.

25 (3) A health carrier shall monitor, on an ongoing basis, the ability, clinical
26 capacity, and legal authority of its providers to furnish all contracted benefits to
27 enrollees. The provisions of this subdivision shall not be construed to require any
28 health care provider to submit copies of such health care provider's income tax
29 returns to a health carrier. A health carrier may require a health care provider
30 to obtain audited financial statements if such health care provider received ten
31 percent or more of the total medical expenditures made by the health carrier.

32 (4) A health carrier shall make its entire network available to all
33 enrollees unless a contract holder has agreed in writing to a different or reduced
34 network.

35 2. A health carrier shall file with the director, in a manner and form
36 defined by rule of the department of insurance, financial institutions and
37 professional registration, an access plan meeting the requirements of sections
38 354.600 to 354.636 for each of the managed care plans that the health carrier
39 offers in this state. The health carrier may request the director to deem sections
40 of the access plan as proprietary or competitive information that shall not be
41 made public. For the purposes of this section, information is proprietary or
42 competitive if revealing the information will cause the health carrier's
43 competitors to obtain valuable business information. The health carrier shall
44 provide such plans, absent any information deemed by the director to be
45 proprietary, to any interested party upon request. The health carrier shall

Unofficial Bill Copy

46 prepare an access plan prior to offering a new managed care plan, and shall
47 update an existing access plan whenever it makes any change as defined by the
48 director to an existing managed care plan. The director shall approve or
49 disapprove the access plan, or any subsequent alterations to the access plan,
50 within sixty days of filing. The access plan shall describe or contain at a
51 minimum the following:
52 (1) The health carrier's network;
53 (2) The health carrier's procedures for making referrals within and
54 outside its network;
55 (3) The health carrier's process for monitoring and assuring on an ongoing
56 basis the sufficiency of the network to meet the health care needs of enrollees of
57 the managed care plan;
58 (4) The health carrier's methods for assessing the health care needs of
59 enrollees and their satisfaction with services;
60 (5) The health carrier's method of informing enrollees of the plan's
61 services and features, including but not limited to the plan's grievance
62 procedures, its process for choosing and changing providers, and its procedures
63 for providing and approving emergency and specialty care;
64 (6) The health carrier's system for ensuring the coordination and
65 continuity of care for enrollees referred to specialty physicians, for enrollees using
66 ancillary services, including social services and other community resources, and
67 for ensuring appropriate discharge planning;
68 (7) The health carrier's process for enabling enrollees to change primary
69 care professionals;
70 (8) The health carrier's proposed plan for providing continuity of care in
71 the event of contract termination between the health carrier and any of its
72 participating providers, in the event of a reduction in service area or in the event
73 of the health carrier's insolvency or other inability to continue operations. The
74 description shall explain how enrollees shall be notified of the contract
75 termination, reduction in service area or the health carrier's insolvency or other
76 modification or cessation of operations, and transferred to other health care
77 professionals in a timely manner; and
78 (9) Any other information required by the director to determine
79 compliance with the provisions of sections 354.600 to 354.636.
80 3. In reviewing an access plan filed pursuant to subsection 2 of this
81 section, the director shall deem a managed care plan's network to be adequate if

Unofficial Bill Copy

82 it meets one or more of the following criteria:
83 (1) The managed care plan is a Medicare + Choice coordinated care plan
84 offered by the health carrier pursuant to a contract with the federal Centers for
85 Medicare and Medicaid Services;
86 (2) The managed care plan is being offered by a health carrier that has
87 been accredited by the National Committee for Quality Assurance at a level of
88 "accredited" or better, and such accreditation is in effect at the time the access
89 plan is filed;
90 (3) The managed care plan's network has been accredited by the Joint
91 Commission on the Accreditation of Health Organizations for Network Adequacy,
92 and such accreditation is in effect at the time the access plan is filed. If the
93 accreditation applies to only a portion of the managed care plan's network, only
94 the accredited portion will be deemed adequate; **[**or**]**
95 (4) The managed care plan is being offered by a health carrier that has
96 been accredited by the Utilization Review Accreditation Commission at a level of
97 "accredited" or better, and such accreditation is in effect at the time the access
98 plan is filed**; or**
99 **(5) The managed care plan is being offered by a health carrier**
100 **that has been accredited by the Accreditation Association for**
101 **Ambulatory Health Care, and such accreditation is in effect at the time**
102 **the access plan is filed**.
374.150. 1. All fees due the state under the provisions of the insurance
2 laws of this state shall be paid to the director **[**of revenue**]** and deposited in the
3 state treasury to the credit of the insurance dedicated fund unless otherwise
4 provided for in subsection 2 of this section.
5 2. There is hereby established in the state treasury a special fund to be
6 known as the "Insurance Dedicated Fund". The fund shall be subject to
7 appropriation of the general assembly and shall be devoted solely to the payment
8 of expenditures incurred by the department attributable to duties performed by
9 the department for the regulation of the business of insurance, regulation of
10 health maintenance organizations and the operation of the division of consumer
11 affairs as required by law which are not paid for by another source of funds.
12 Other provisions of law to the contrary notwithstanding, beginning on January
13 1, 1991, all fees charged under any provision of chapter 325, 354, 374, 375, 376,
14 377, 378, 379, 380, 381, 382, 383, 384 or 385 due the state shall be paid into this
15 fund. The state treasurer shall invest moneys in this fund in the same manner

Unofficial Bill Copy

16 as other state funds and any interest or earnings on such moneys shall be
17 credited to the insurance dedicated fund. The provisions of section 33.080
18 notwithstanding, moneys in the fund shall not lapse, be transferred to or placed
19 to the credit of the general revenue fund unless and then only to the extent to
20 which the unencumbered balance at the close of the biennium year exceeds two
21 times the total amount appropriated, paid, or transferred to the fund during such
22 fiscal year.

23 **[**3. Notwithstanding provisions of this section to the contrary, five
24 hundred thousand dollars of the insurance dedicated fund shall annually be
25 transferred and placed to the credit of the state general revenue fund on July
26 first beginning with fiscal year 2014.**]**

374.230. Every **[**insurance company doing business in this state**]**
2 **individual or entity making a filing with the department described**
3 **below** shall pay to the director **[**of revenue**]** the following fees **and charges, to**
4 **be paid into the insurance dedicated fund established under section**
5 **374.150**:

6 (1) For filing the declaration required on organization of each domestic
7 company, **[**two hundred fifty**]** **one thousand** dollars;

8 (2) For filing statement and certified copy of charter required of foreign
9 companies, **[**two hundred fifty**]** **one thousand** dollars;

10 (3) For filing application to renew certificate of authority, along with all
11 required annual reports, including the annual statement, actuarial statement,
12 risk-based capital report, report of valuation of policies or other obligations of
13 assurance, and audited financial report annual statement of any company doing
14 business in this state, **[**one thousand five hundred**]** **two thousand** dollars;

15 (4) **[**For filing supplementary annual statement of any company doing
16 business in this state, fifty dollars**]** **For filing the ORSA summary report**
17 **required by sections 382.500 to 382.550, or a preacquisition notification**
18 **required by sections 382.040 through 382.060, or section 382.095, five**
19 **hundred dollars**;

20 (5) **Unless otherwise specified in subdivision (4) or another**
21 **section of law, for any filings required under chapter 382, two hundred**
22 **fifty dollars;**

23 **(6)** For filing any paper, document, or report **for which a filing fee is**
24 **not otherwise provided for in another section of law that is** not filed
25 under subdivision (1), (2), **[**or**]** (3), **(4), or (5),** but required to be filed in the office

Unofficial Bill Copy

26 of the director, [fifty] **one hundred fifty** dollars each[;].

27 [(6) For a copy of a company's certificate of authority or producer or agent
28 license, ten dollars;

29 (7) For affixing the seal of office of the director, ten dollars;

30 (8) For accepting each service of process upon the company, ten dollars.]

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

2 (1) **"Health benefit plan", as such term is defined in section**
3 **376.1350;**

4 **(2)** "Health care services", medical, surgical, dental, podiatric,
5 pharmaceutical, chiropractic, licensed ambulance service, and optometric services;

6 **(3) "Health carrier" or "carrier", as such term is defined in section**
7 **376.1350;**

8 [(2)] **(4)** "Insured", any person entitled to benefits under a contract of
9 accident and sickness insurance, or medical-payment insurance issued as a
10 supplement to liability insurance but not including any other coverages contained
11 in a liability or a workers' compensation policy, issued by an insurer;

12 [(3)] **(5)** "Insurer", any person, reciprocal exchange, interinsurer,
13 fraternal benefit society, health services corporation, self-insured group
14 arrangement to the extent not prohibited by federal law, or any other legal entity
15 engaged in the business of insurance;

16 [(4)] **(6)** "Provider", a physician, hospital, dentist, podiatrist,
17 chiropractor, pharmacy, licensed ambulance service, or optometrist, licensed by
18 this state.

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

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

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

Unofficial Bill Copy

32 **5. When a patient's health benefit plan does not include or**
33 **require payment to out-of-network providers for all or most covered**
34 **services, which would otherwise be covered if the patient received such**
35 **services from a provider in the carrier's network, including but not**
36 **limited to health maintenance organization plans, as such term is**
37 **defined in section 354.400, or a health benefit plan offered by a carrier**
38 **consistent with subdivision (19) of section 376.426, payment for all**
39 **services shall be made directly to the providers when the health carrier**
40 **has authorized such services to be received from a provider outside the**
41 **carrier's network.**

376.690. 1. As used in this section, the following terms shall
2 **mean:**
3 **(1) "Emergency medical condition", the same meaning given to**
4 **such term in section 376.1350;**
5 **(2) "Facility", the same meaning given to such term in section**
6 **376.1350;**
7 **(3) "Health care professional", the same meaning given to such**
8 **term in section 376.1350;**
9 **(4) "Health carrier", the same meaning given to such term in**
10 **section 376.1350;**
11 **(5) "Unanticipated out-of-network care", health care services**
12 **received by a patient in an in-network facility from an out-of-network**
13 **health care professional from the time the patient presents with an**
14 **emergency medical condition until the time the patient is discharged;**
15 **2. Health care professionals may send any claim for charges**
16 **incurred for unanticipated out-of-network care to the patient's health**
17 **carrier within one hundred and eighty days of the delivery of the**
18 **unanticipated out-of-network care on a U.S. Centers of Medicare and**
19 **Medicaid Services Form 1500, or its successor form, or electronically**
20 **using the 837 HIPAA format, or its successor.**
21 **(1) Within forty-five processing days, as defined in 376.383, of**
22 **receiving the health care professional's claim, the health carrier shall**
23 **offer to pay the health care professional a reasonable reimbursement**
24 **for unanticipated out-of-network care based on the health care**
25 **professional's services. If the health care professional participates in**
26 **one or more of the carrier's commercial networks, the offer of**
27 **reimbursement for unanticipated out-of-network care shall be the**

Unofficial Bill Copy

28 **amount from the network which has the highest reimbursement.**

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

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

38 **(4) To initiate arbitration proceedings, either the health carrier**
39 **or health care professional must provide written notification to the**
40 **director and the other party within 120 days of the end of the**
41 **negotiation period, indicating their intent to arbitrate the matter and**
42 **notifying the director of the billed amount and the date and amount of**
43 **the final offer by each party. A claim for unanticipated out of network**
44 **care may be resolved between the parties at any point prior to the**
45 **commencement of the arbitration proceedings. Claims may be**
46 **combined for purposes of arbitration, but only to the extent the claims**
47 **represent similar circumstances and services provided by the same**
48 **health care professional, and the parties attempted to resolve the**
49 **dispute in accordance with subdivisions (2) through (4) of this**
50 **subsection.**

51 **(5) No health care professional who sends a claim to a health**
52 **carrier under subsection 2 of this section shall send a bill to the patient**
53 **for any difference between the reimbursement rate as determined**
54 **under this subsection and the health care professional's billed charge.**

55 **3. When unanticipated out-of-network care is provided, the**
56 **health care professional who sends a claim to a health carrier under**
57 **subsection 2 of this section may bill a patient for no more than the cost-**
58 **sharing requirements described under this section.**

59 **(1) Cost-sharing requirements shall be based on the**
60 **reimbursement amount as determined under subsection 2 of this**
61 **section.**

62 **(2) The patient's health carrier shall inform the health care**
63 **professional of its enrollee's cost-sharing requirements within forty-five**
64 **processing days of receiving a claim from the health care professional**

Unofficial Bill Copy

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

Unofficial Bill Copy

102 **professional believes the payment offered for the unanticipated out-of-**
103 **network care does not properly recognize:**
104 **(1) The health care professional's training, education, or**
105 **experience;**
106 **(2) The nature of the service provided;**
107 **(3) The health care professional's usual charge for comparable**
108 **services provided;**
109 **(4) The circumstances and complexity of the particular case,**
110 **including the time and place the services were provided; and**
111 **(5) The average contracted rate for comparable services**
112 **provided in the same geographic area.**
113 **8. The enrollee shall not be required to participate in the**
114 **arbitration process. The health care professional and health carrier**
115 **shall execute a nondisclosure agreement prior to engaging in an**
116 **arbitration under this section.**
117 **9. This section shall take effect on January 1, 2019.**
118 **10. The department of insurance, financial institutions and**
119 **professional registration may promulgate rules and fees as necessary**
120 **to implement the provisions of this section, including but not limited**
121 **to, procedural requirements for arbitration. Any rule or portion of a**
122 **rule, as that term is defined in section 536.010 that is created under the**
123 **authority delegated in this section shall become effective only if it**
124 **complies with and is subject to all of the provisions of chapter 536, and,**
125 **if applicable, section 536.028. This section and chapter 536 are**
126 **nonseverable and if any of the powers vested with the general assembly**
127 **pursuant to chapter 536, to review, to delay the effective date, or to**
128 **disapprove and annul a rule are subsequently held unconstitutional,**
129 **then the grant of rulemaking authority and any rule proposed or**
130 **adopted after August 28, 2018, shall be invalid and void.**
376.1065. 1. As used in this section, the following terms shall
2 **mean:**
3 **(1) "Contracting entity", any health carrier, as such term is**
4 **defined in section 376.1350, subject to the jurisdiction of the**
5 **department engaged in the act of contracting with providers for the**
6 **delivery of dental services, or the selling or assigning of dental network**
7 **plans to other entities under the jurisdiction of the department;**
8 **(2) "Department", the department of insurance, financial**

Unofficial Bill Copy

9 **institutions and professional registration;**

10 **(3) "Official notification," written communication by a provider**
11 **or participating provider to a contracting entity describing such**
12 **provider's or participating provider's change in contact information or**
13 **participation status with the contracting entity;**

14 **(4) "Participating provider", a provider who has an agreement**
15 **with a contracting entity to provide dental services with an expectation**
16 **of receiving payment, other than coinsurance, co-payments, or**
17 **deductibles, directly or indirectly from such contracting entity;**

18 **(5) "Provider", any person licensed under chapter 332.**

19 **2. A contracting entity shall, upon official notification, make**
20 **changes contained in the official notification to their electronic**
21 **provider material and their next edition of paper material made**
22 **available to plan members or other potential plan members.**

23 **3. The department, when determining the result of a market**
24 **conduct examination under sections 374.202 to 374.207, shall consider**
25 **violations of this section by a contracting entity.**

376.1350. For purposes of sections 376.1350 to 376.1390, the following
2 terms mean:

3 (1) "Adverse determination", a determination by a health carrier or its
4 designee utilization review organization that an admission, availability of care,
5 continued stay or other health care service has been reviewed and, based upon
6 the information provided, does not meet the health carrier's requirements for
7 medical necessity, appropriateness, health care setting, level of care or
8 effectiveness, and the payment for the requested service is therefore denied,
9 reduced or terminated;

10 (2) "Ambulatory review", utilization review of health care services
11 performed or provided in an outpatient setting;

12 (3) "Case management", a coordinated set of activities conducted for
13 individual patient management of serious, complicated, protracted or other health
14 conditions;

15 (4) "Certification", a determination by a health carrier or its designee
16 utilization review organization that an admission, availability of care, continued
17 stay or other health care service has been reviewed and, based on the information
18 provided, satisfies the health carrier's requirements for medical necessity,
19 appropriateness, health care setting, level of care and effectiveness;

Unofficial Bill Copy

20 (5) "Clinical peer", a physician or other health care professional who holds
21 a nonrestricted license in a state of the United States and in the same or similar
22 specialty as typically manages the medical condition, procedure or treatment
23 under review;
24 (6) "Clinical review criteria", the written screening procedures, decision
25 abstracts, clinical protocols and practice guidelines used by the health carrier to
26 determine the necessity and appropriateness of health care services;
27 (7) "Concurrent review", utilization review conducted during a patient's
28 hospital stay or course of treatment;
29 (8) "Covered benefit" or "benefit", a health care service that an enrollee
30 is entitled under the terms of a health benefit plan;
31 (9) "Director", the director of the department of insurance, financial
32 institutions and professional registration;
33 (10) "Discharge planning", the formal process for determining, prior to
34 discharge from a facility, the coordination and management of the care that a
35 patient receives following discharge from a facility;
36 (11) "Drug", any substance prescribed by a licensed health care provider
37 acting within the scope of the provider's license and that is intended for use in
38 the diagnosis, mitigation, treatment or prevention of disease. The term includes
39 only those substances that are approved by the FDA for at least one indication;
40 (12) "Emergency medical condition", the sudden and, at the time,
41 unexpected onset of a health condition that manifests itself by symptoms of
42 sufficient severity**, regardless of the final diagnosis that is given,** that
43 would lead a prudent lay person, possessing an average knowledge of medicine
44 and health, to believe that immediate medical care is required, which may
45 include, but shall not be limited to:
46 (a) Placing the person's health in significant jeopardy;
47 (b) Serious impairment to a bodily function;
48 (c) Serious dysfunction of any bodily organ or part;
49 (d) Inadequately controlled pain; or
50 (e) With respect to a pregnant woman who is having contractions:
51 a. That there is inadequate time to effect a safe transfer to another
52 hospital before delivery; or
53 b. That transfer to another hospital may pose a threat to the health or
54 safety of the woman or unborn child;
55 (13) "Emergency service", a health care item or service furnished or

Unofficial Bill Copy

56 required to evaluate and treat an emergency medical condition, which may
57 include, but shall not be limited to, health care services that are provided in a
58 licensed hospital's emergency facility by an appropriate provider;
59 (14) "Enrollee", a policyholder, subscriber, covered person or other
60 individual participating in a health benefit plan;
61 (15) "FDA", the federal Food and Drug Administration;
62 (16) "Facility", an institution providing health care services or a health
63 care setting, including but not limited to hospitals and other licensed inpatient
64 centers, ambulatory surgical or treatment centers, skilled nursing centers,
65 residential treatment centers, diagnostic, laboratory and imaging centers, and
66 rehabilitation and other therapeutic health settings;
67 (17) "Grievance", a written complaint submitted by or on behalf of an
68 enrollee regarding the:
69 (a) Availability, delivery or quality of health care services, including a
70 complaint regarding an adverse determination made pursuant to utilization
71 review;
72 (b) Claims payment, handling or reimbursement for health care services;
73 or
74 (c) Matters pertaining to the contractual relationship between an enrollee
75 and a health carrier;
76 (18) "Health benefit plan", a policy, contract, certificate or agreement
77 entered into, offered or issued by a health carrier to provide, deliver, arrange for,
78 pay for, or reimburse any of the costs of health care services; except that, health
79 benefit plan shall not include any coverage pursuant to liability insurance policy,
80 workers' compensation insurance policy, or medical payments insurance issued
81 as a supplement to a liability policy;
82 (19) "Health care professional", a physician or other health care
83 practitioner licensed, accredited or certified by the state of Missouri to perform
84 specified health services consistent with state law;
85 (20) "Health care provider" or "provider", a health care professional or a
86 facility;
87 (21) "Health care service", a service for the diagnosis, prevention,
88 treatment, cure or relief of a health condition, illness, injury or disease;
89 (22) "Health carrier", an entity subject to the insurance laws and
90 regulations of this state that contracts or offers to contract to provide, deliver,
91 arrange for, pay for or reimburse any of the costs of health care services,

Unofficial Bill Copy

92 including a sickness and accident insurance company, a health maintenance
93 organization, a nonprofit hospital and health service corporation, or any other
94 entity providing a plan of health insurance, health benefits or health services;
95 except that such plan shall not include any coverage pursuant to a liability
96 insurance policy, workers' compensation insurance policy, or medical payments
97 insurance issued as a supplement to a liability policy;

98 (23) "Health indemnity plan", a health benefit plan that is not a managed
99 care plan;

100 (24) "Managed care plan", a health benefit plan that either requires an
101 enrollee to use, or creates incentives, including financial incentives, for an
102 enrollee to use, health care providers managed, owned, under contract with or
103 employed by the health carrier;

104 (25) "Participating provider", a provider who, under a contract with the
105 health carrier or with its contractor or subcontractor, has agreed to provide
106 health care services to enrollees with an expectation of receiving payment, other
107 than coinsurance, co-payments or deductibles, directly or indirectly from the
108 health carrier;

109 (26) "Peer-reviewed medical literature", a published scientific study in a
110 journal or other publication in which original manuscripts have been published
111 only after having been critically reviewed for scientific accuracy, validity and
112 reliability by unbiased independent experts, and that has been determined by the
113 International Committee of Medical Journal Editors to have met the uniform
114 requirements for manuscripts submitted to biomedical journals or is published in
115 a journal specified by the United States Department of Health and Human
116 Services pursuant to Section 1861(t)(2)(B) of the Social Security Act, as amended,
117 as acceptable peer-reviewed medical literature. Peer-reviewed medical literature
118 shall not include publications or supplements to publications that are sponsored
119 to a significant extent by a pharmaceutical manufacturing company or health
120 carrier;

121 (27) "Person", an individual, a corporation, a partnership, an association,
122 a joint venture, a joint stock company, a trust, an unincorporated organization,
123 any similar entity or any combination of the foregoing;

124 (28) "Prospective review", utilization review conducted prior to an
125 admission or a course of treatment;

126 (29) "Retrospective review", utilization review of medical necessity that
127 is conducted after services have been provided to a patient, but does not include

Unofficial Bill Copy

128 the review of a claim that is limited to an evaluation of reimbursement levels,
129 veracity of documentation, accuracy of coding or adjudication for payment;

130 (30) "Second opinion", an opportunity or requirement to obtain a clinical
131 evaluation by a provider other than the one originally making a recommendation
132 for a proposed health service to assess the clinical necessity and appropriateness
133 of the initial proposed health service;

134 (31) "Stabilize", with respect to an emergency medical condition, that no
135 material deterioration of the condition is likely to result or occur before an
136 individual may be transferred;

137 (32) "Standard reference compendia":

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

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

140 (33) "Utilization review", a set of formal techniques designed to monitor
141 the use of, or evaluate the clinical necessity, appropriateness, efficacy, or
142 efficiency of, health care services, procedures, or settings. Techniques may
143 include ambulatory review, prospective review, second opinion, certification,
144 concurrent review, case management, discharge planning or retrospective
145 review. Utilization review shall not include elective requests for clarification of
146 coverage;

147 (34) "Utilization review organization", a utilization review agent as
148 defined in section 374.500.

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

3 (1) A health carrier shall cover emergency services necessary to screen
4 and stabilize an enrollee**, as determined by the treating emergency**
5 **department health care provider,** and shall not require prior authorization
6 of such services;

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

9 (3) **Before a health carrier denies payment for an emergency**
10 **medical service based on the absence of an emergency medical**
11 **condition, it shall review the enrollee's medical record regarding the**
12 **emergency medical condition at issue. If a health carrier requests**
13 **records for a potential denial where emergency services were rendered,**
14 **the health care provider shall submit the record of the emergency**
15 **services to the carrier within forty-five processing days, or the claim**

Unofficial Bill Copy

shall be subject to section 376.383. The health carrier's review of emergency services shall be completed by a board-certified physician licensed under chapter 334 to practice medicine in this state;

(4) 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**;**

(5) When a patient's health benefit plan does not include or require payment to out-of-network health care providers for emergency services including but not limited to health maintenance organization plans, as defined in section 354.400, or a health benefit plan offered by a health carrier consistent with subdivision (19) of section 376.426, payment for all emergency services as defined in section 376.1350 necessary to screen and stabilize an enrollee shall be paid directly to the health care provider by the health carrier. Additionally, any services authorized by the health carrier for the enrollee once the enrollee is stabilized shall also be paid by the health carrier directly to the health care provider.

379.1545. Notwithstanding any other provision of law:

(1) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty days' notice;

(2) If the insurer changes the terms and conditions of a policy of portable electronics insurance, the insurer shall provide the vendor and any policyholders with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of material changes;

(3) Notwithstanding subdivision (1) of this section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder;

(4) Notwithstanding subdivision (1) of this section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

18 (a) For nonpayment of premium;
19 (b) If the enrolled customer ceases to have an active service with the
20 vendor of portable electronics; or
21 (c) If an enrolled customer exhausts the aggregate limit of liability, if any,
22 under the terms of the portable electronics insurance policy and the insurer sends
23 notice of termination to the customer within thirty calendar days after exhaustion
24 of the limit. However, if the notice is not timely sent, enrollment and coverage
25 shall continue notwithstanding the aggregate limit of liability until the insurer
26 sends notice of termination to the enrolled customer;
27 (5) Where a portable electronics insurance policy is terminated by a
28 policyholder, the policyholder shall mail or deliver written notice to each enrolled
29 customer advising the customer of the termination of the policy and the effective
30 date of termination. The written notice shall be mailed or delivered to the
31 customer at least thirty days prior to the termination;
32 (6) Whenever notice is required under this section, it shall be in writing
33 and may be mailed or delivered to the vendor at the vendor's mailing address and
34 to its affected enrolled customers' last known mailing addresses on file with the
35 insurer. If notice is mailed, the insurer or vendor, as the case may be, shall
36 maintain proof of mailing in a form authorized or accepted by the U.S. Postal
37 Service or other commercial mail delivery service. Alternatively, an insurer or
38 vendor policyholder may comply with any notice required by this section by
39 providing electronic notice to a vendor or its affected enrolled customers, as the
40 case may be, by electronic means. **For purposes of this subdivision,**
41 **agreement to receive notices and correspondence by electronic means**
42 **shall be determined in accordance with section 432.220.** Additionally, if
43 an insurer or vendor policyholder provides electronic notice to an affected enrolled
44 customer and such delivery by electronic means is not available or is
45 undeliverable, the insurer or vendor policyholder shall provide written notice to
46 the enrolled customer by mail in accordance with this section. If notice is
47 accomplished through electronic means, the insurer or vendor of portable
48 electronics, as the case may be, shall maintain proof that the notice was sent.

[374.115. Insurance examiners appointed or employed by the
2 director of the department of insurance, financial institutions and
3 professional registration shall be compensated according to the
4 applicable levels established and published by the National
5 Association of Insurance Commissioners.**]**

Unofficial Bill Copy

Section B. The repeal of section 374.115 and the repeal and reenactment
2 of sections 354.150, 354.495, 374.150, and 374.230 of section A of this act shall
3 become effective on January 1, 2019.

✓

Unofficial

Bill

Copy