SECOND REGULAR SESSION

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

SENATE SUBSTITUTE FOR

SENATE BILL NO. 608

98TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SATER.

Offered February 10, 2016.

Senate Substitute adopted, February 10, 2016.

Taken up for Perfection February 10, 2016. Bill declared Perfected and Ordered Printed, as amended.

ADRIANE D. CROUSE, Secretary.

4834S.03P

AN ACT

To amend chapter 208, RSMo, by adding thereto four new sections relating to MO HealthNet health care provider fees.

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

Section A. Chapter 208, RSMo, is amended by adding thereto four new sections, to be known as sections 191.875, 208.142, 208.148, and 376.2020, to read as follows:

191.875. 1. This section shall be known as the "Health Care Cost Reduction and Transparency Act".

2. As used in this section, the following terms shall mean:

(1) "Department", the department of health and senior services;

(2) "DRG", diagnosis related group;

(3) "Estimate of cost", an estimate based on the information entered and assumptions about typical utilization and costs for health care services. Such estimates of cost shall encompass only those services within the direct control of the health care provider and shall include the following:

(a) The amount that will be charged to a patient for the health services if all charges are paid in full without a public or private third party paying for any portion of the charges;

(b) The average negotiated settlement on the amount that will be charged to a patient required to be provided in paragraph (a) of this subdivision;

(c) The amount of any MO HealthNet reimbursement for the health care services, including claims and pro rata supplemental payments, if known;

(d) The amount of any Medicare reimbursement for the medical services, if known; and

(e) The amount of any insurance copayments for the health benefit plan of the patient, if known;

(4) "Health care provider", any ambulatory surgical center, assistant physician, chiropractor, clinical psychologist, dentist, hospital, long-term care facility, nurse anesthetist, optometrist, pharmacist, physical therapist, physician, physician assistant, podiatrist, registered nurse, or other licensed health care facility or professional providing health care services in this state;

(5) "Health carrier", an entity as such term is defined under section 376.1350;

(6) "Hospital", as such term is defined under section 197.020;

(7) "Insurance costs", an estimate of cost of covered services provided by a health carrier based on a specific insured's coverage and health care services to be provided. Such insurance cost shall include:

(a) The average negotiated reimbursement amount to any health care provider;

(b) Any deductibles, copayments, or coinsurance amounts, including those whose disclosure is mandated under section 376.446; and

(c) Any amounts not covered under the health benefit plan;

(8) "Public or private third party", a state government, the federal government, employer, health carrier, third-party administrator, or managed care organization.

3. On or after July 1, 2017, any patient or consumer of health care services who makes a written request for an estimate of the cost of health care services from a health care provider shall be provided such estimate no later than five business days after receiving such request, except when the requested information is posted on the department's website under subsection 8 of this section. Any patient or consumer of health care services who makes a written request for the insurance costs from such patient's or consumer's health carrier shall be provided such insurance costs no later than five business days

after receiving such request. The provisions of this subsection shall not apply to emergency health care services.

4. Health care providers, and the department under subsection 8 of this section, shall include with any estimate of costs the following: "Your estimated cost is based on the information entered and assumptions about typical utilization and costs. The actual amount billed to you may be different from the estimate of costs provided to you. Many factors affect the actual bill you will receive, and this estimate of costs does not account for all of them. Additionally, the estimate of costs is not a guarantee of insurance coverage. You will be billed at the health care provider's charge for any service provided to you that is not a covered benefit under your plan. Please check with your insurance company to receive an estimate of the amount you will owe under your plan or if you need help understanding your benefits for the service chosen.".

5. Health carriers shall include with any insurance costs the following: "Your insurance costs are based on the information entered and assumptions about typical utilization and costs. The actual amount of insurance costs and the amount billed to you may be different from the insurance costs provided to you. Many factors affect the actual insurance costs, and the insurance costs provided do not account for all of them. Additionally, the insurance costs provided are limited to the specific information provided and are not a guarantee of insurance coverage for additional services. You will be billed at the health care provider's charge for any service provided to you that is not a covered benefit under your plan. You may contact us if you need further assistance in understanding your benefits for the service chosen.".

6. Each health care provider shall also make available the percentage or amount of any discounts for cash payment of any charges incurred through the health care provider's website or by making it available at the health care provider's location.

7. Nothing in this section shall be construed as violating any health care provider contract provisions with a health carrier that prohibit disclosure of the health care provider's fee schedule with a health carrier to third parties.

8. The department shall make available to the public on its website the most current price information it receives from hospitals

under subsections 9 and 10 of this section. The department shall provide this information in a manner that is easily understood by the public and meets the following minimum requirements:

(1) Information for each participating hospital shall be listed separately and hospitals shall be listed in groups by category as determined by the department in rules adopted under this section; and

(2) Information for each hospital outpatient department shall be listed separately.

9. Beginning with the quarter ending June 30, 2017, and quarterly thereafter, each participating hospital shall provide to the department, in the manner and format determined by the department, the following information about the one hundred most frequently reported admissions by DRG for inpatients as established by the department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges;

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection;

(3) The amount of MO HealthNet reimbursement for each DRG, including claims and pro rata supplemental payments; and

(4) The amount of Medicare reimbursement for each DRG.

A hospital shall not report or be required to report the information required by this subsection for any of the one hundred most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

10. Beginning with the quarter ending June 30, 2017, and quarterly thereafter, each participating hospital shall provide to the department, in a manner and format determined by the department, information on the total costs for the twenty most common outpatient surgical procedures and the twenty most common imaging procedures, by volume, performed in hospital outpatient settings. Participating hospitals shall report this information in the same manner as required by subsection 9 of this section, provided that hospitals shall not report

or be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of HIPAA or other federal law.

11. A hospital shall provide the information specified under subsections 9 and 10 of this section to the department. A hospital which does so shall not be required to provide that information pursuant to subsection 3 of this section.

12. Any data disclosed to the department by a hospital under subsections 9 and 10 of this section shall be the sole property of the hospital that submitted the data. Any data or product derived from the data disclosed under subsections 9 and 10 of this section, including a consolidation or analysis of the data, shall be the sole property of the state. Any proprietary information received by the department shall be a proprietary interest and may be closed under the provisions of subdivision (15) of section 610.021. The department shall not allow information it receives or discloses under subsections 9 and 10 of this section to be used by any person or entity for commercial purposes.

13. The department shall promulgate rules to implement the provisions of this section. The rules relating to subsections 8 to 12 of this section shall include all of the following:

(1) The one hundred most frequently reported DRGs for inpatients for which participating hospitals will provide the data required under subsection 9 of this section;

(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the department's website; and

(3) The twenty most common outpatient surgical procedures and the twenty most common imaging procedures, by volume, performed in a hospital outpatient setting required under subsection 10 of this section.

Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to

delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall be invalid and void.

208.142. 1. Beginning October 1, 2016, a MO HealthNet participant who uses hospital emergency department services for the treatment of a medical condition that is not an emergency medical condition shall be required to pay a copayment fee of eight dollars for such services. A participant shall be notified of the eight dollar copayment prior to services being rendered. A MO HealthNet participant's failure to pay the copayment fee shall not in any way reduce or otherwise affect any MO HealthNet reimbursement to the health care provider for the services provided.

2. For the purposes of this section, an "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(2) Serious impairment to bodily functions;

(3) Serious dysfunction of any bodily organ or part.

3. The department of social services shall promulgate rules for the implementation of this section, including setting forth rules for the required documentation by the physician and the informed consent to be provided to and signed by the parent or guardian of the participant. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536, are nonseverable, and if any of the powers vested with the general assembly under chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall

be invalid and void.

4. The department shall submit such state plan amendments and waivers to the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services as the department determines are necessary to implement the provisions of this section.

208.148. 1. Except as required to satisfy laws pertaining to the termination of patient care without adequate notice or without making other arrangements for the continued care of the patient, fee-for-service MO HealthNet health care providers shall be permitted to prohibit a MO HealthNet participant who misses an appointment or fails to provide notice of cancellation within twenty-four hours prior to the appointment from scheduling another appointment until the participant has paid a missed appointment fee to the health care provider as follows:

(1) For the first missed appointment in a three-year period, no fee shall be charged but such missed appointment shall be documented in the patient's record;

(2) For the second missed appointment in a three-year period, a fee of no greater than five dollars;

(3) For the third missed appointment in a three-year period, a fee of no greater than ten dollars; and

(4) For the fourth and each subsequent missed appointment in a three-year period, a fee of no greater than twenty dollars.

Such health care providers shall waive the missed appointment fee in cases of inclement weather.

2. Nothing in this section shall be construed in any way to limit MO HealthNet managed care organizations from developing and implementing any incentive program to encourage adherence to scheduled appointments.

3. The health care provider shall not charge to nor shall the MO Healthnet participant be reimbursed by the MO HealthNet program for the missed appointment fee.

4. The department shall submit such state plan amendments and waivers to the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services as the department determines are necessary to implement the provisions of this section.

376.2020. 1. For purposes of this section, the following terms

shall mean:

(1) "Contractual payment amount" or "payment amount", shall mean the total amount a health care provider is to be paid for providing a given health care service pursuant to a contract with a health carrier, and includes both the portions to be paid by the patient and by the health carrier. It is commonly referred to as the allowable amount;

(2) "Enrollee", shall have the same meaning ascribed to it in section 376.1350;

(3) "Health care provider", shall have the same meaning ascribed to it in section 376.1350;

(4) "Health care service", shall have the same meaning ascribed to it in section 376.1350;

(5) "Health carrier", shall have the same meaning ascribed to it in section 376.1350.

2. No provision in a contract in existence or entered into, amended, or renewed on or after August 28, 2016, between a health carrier and a health care provider shall be enforceable if such contractual provision prohibits, conditions, or in any way restricts any party to such contract from disclosing to an enrollee, patient, potential patient, or such person's parent or legal guardian, the contractual payment amount for a health care service if such payment amount is less than the health care provider's usual charge for the health care service, and if such contractual provision prevents the determination of the potential out-of-pocket cost for the health care service by the enrollee, patient, potential patient, parent, or legal guardian.

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