FIRST REGULAR SESSION

HOUSE BILL NO. 569

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES MOLENDORP (Sponsor) AND WILSON (130) (Co-sponsor).

1636L.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 376.383, RSMo, and to enact in lieu thereof two new sections relating to health insurance.

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

Section A. Section 376.383, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 376.383 and 376.1214, to read as follows:

376.383. 1. For purposes of this section and section 376.384, the following terms shall mean:

(1) "Claimant", any individual, corporation, association, partnership or other legal entity asserting a right to payment arising out of a contract or a contingency or loss covered under a health benefit plan as defined in section 376.1350;

(2) "Deny" or "denial", when the health carrier refuses to reimburse all or part of the claim;

(3) "Health carrier", health carrier as defined in section 376.1350, except that health carrier shall not include a workers' compensation carrier providing benefits to an employee pursuant to chapter 287, RSMo;

(4) "Health care provider", health care provider as defined in section 376.1350;

(5) "Health care services", health care services as defined in section 376.1350;

(6) "Processing days", number of days the health carrier has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a request for additional information;

(7) "Request for additional information", when the health carrier requests information from the claimant to determine if all or part of the claim will be reimbursed;

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.

(8) "Suspends the claim", giving notice to the claimant specifying the reason the claim is not yet paid, including but not limited to grounds as listed in the contract between the claimant and the health carrier; and

(9) "Third-party contractor", a third party contracted with the health carrier to receive or process claims for reimbursement of health care services.

2. Within ten working days after receipt of a claim by a health carrier or a third-party contractor, a health carrier shall:

(1) Send an acknowledgment of the date of receipt; or

(2) Send notice of the status of the claim that includes a request for additional information. If a health carrier pays the claim, subdivisions (1) and (2) shall not apply.

3. Within fifteen days after receipt of additional information by a health carrier or a third-party contractor, a health carrier shall pay the claim or any undisputed part of the claim in accordance with this section or send a notice of receipt and status of the claim:

(1) That denies all or part of the claim and specifies each reason for denial; or

(2) That makes a final request for additional information.

4. Within fifteen days after the day on which the health carrier or a third-party contractor receives the additional requested information in response to a final request for information, it shall pay the claim or any undisputed part of the claim or deny or suspend the claim.

5. If the health carrier has not paid the claimant on or before the forty-fifth **processing** day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month. The interest shall be calculated based upon the unpaid balance of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest. A health carrier may combine interest payments and make payment once the aggregate amount reaches five dollars.

6. If a health carrier fails to pay, deny or suspend the claim within forty processing days, and has received, on or after the fortieth day, notice from the health care provider that such claim has not been paid, denied or suspended, the health carrier shall, in addition to monthly interest due, pay to the claimant per day an amount of fifty percent of the claim but not to exceed twenty dollars for failure to pay all or part of a claim or interest due thereon or deny or suspend as required by this section. Such penalty shall not accrue for more than thirty days unless the claimant provides a second written or electronic notice on or after the thirty days to the health carrier that the claim remains unpaid and that penalties are claimed to be due pursuant to this section. Penalties shall cease if the health carrier pays, denies or suspends the claim. Said penalty shall also cease to accrue on the day after a petition is filed in a court of competent jurisdiction to recover payment of said claim. Upon a finding by a court of competent

jurisdiction that the health carrier failed to pay a claim, interest or penalty without reasonable cause, the court shall enter judgment for reasonable attorney fees for services necessary for recovery. Upon a finding that a provider filed suit without reasonable grounds to recover a claim, the court shall award the health carrier reasonable attorney fees necessary to the defense.

7. The department of insurance, financial institutions and professional registration shall monitor suspensions and determine whether the health carrier acted reasonably.

8. If a health carrier or third-party contractor has reasonable grounds to believe that a fraudulent claim is being made, the health carrier or third-party contractor shall notify the department of insurance, financial institutions and professional registration of the fraudulent claim pursuant to sections 375.991 to 375.994, RSMo.

9. Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied.

10. Requests for additional information shall specify what additional information is necessary to process the claim for payment. Information requested shall be reasonable and pertain to the health carrier's determination of liability. The health carrier shall acknowledge receipt of the requested additional information to the claimant within five working days or pay the claim.

376.1214. 1. As used in this section, the following terms shall mean:

(1) "Autism spectrum disorder", any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including autistic disorder, Asperger's disorder, childhood disintegrative disorder, pervasive developmental disorder not otherwise specified (NOS), and Rett's syndrome;

(2) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Medical services", includes:

(a) Clinical evaluation and assessment services;

(b) Behavior modification, family therapy, or other forms of psychotherapy;

(c) Speech therapy;

(d) Occupational therapy;

(e) Physical therapy;

(f) Prescription drugs, if covered by the plan, used to address the symptoms of autism spectrum disorder; and

(g) Medical care and treatment for comorbid conditions.

2. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after August 28, 2010, shall offer group coverage for enrollees diagnosed with autism spectrum disorder for all necessary medical services prescribed in relation to such disorder by the enrollee's physician in the treatment plan recommended by such physician. An individual providing treatment prescribed under this subsection shall be an appropriately licensed health care practitioner.

3. Coverage under this section is subject to all terms and conditions including medical necessity, definitions, restrictions, exclusions, and limitations that apply to any other coverage under the plan, including the treatment under the plan performed by participating and nonparticipating providers.

4. No benefits shall be available for services, supplies, or equipment:

(1) For which the enrollee has no legal obligation to pay in the absence of such coverage or like coverage;

(2) Provided to the enrollee or eligible dependent by a publicly funded program;

(3) Provided by a family member;

(4) Provided by unlicensed providers;

(5) Rendered in educational or instructional programs, or that are educational, vocational, or training in nature, including those services, supplies, or equipment required to be provided by public or private school districts or state or local educational agencies to children who have a disability under the federal Individuals with Disabilities in Education Act (IDEA), 20 U.S.C. Section 1404, et seq., as amended, and similar state and local laws and regulations implementing IDEA; and

(6) That are supervisory services not directly provided to the enrollee or an eligible dependent.

5. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months' or less duration, or any other supplemental policy.

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