HCS HB 497 -- TRANSPARENCY OF HEALTH CARE INFORMATION, MISSOURI HEALTH INSURANCE POOL, AND PATIENT PRIVACY AND SAFETY

SPONSOR: Wilson, 130 (Ervin)

COMMITTEE ACTION: Voted "do pass" by the Special Committee on Health Insurance by a vote of 8 to 4.

This substitute changes the laws regarding transparency of health care information, Missouri Health Insurance Pool, and patient privacy and safety.

PRIVACY OF HEALTH CARE INFORMATION

The substitute establishes the Missouri Patient Privacy Act which prohibits the disclosure of patient-specific health information to any employer, public or private payer, or employee or agent of a state department or agency without the written consent of the patient and health care provider. Health information may be disclosed to a health insurer, employer, state employee or agent of the Missouri Consolidated Health Care Plan, the Department of Health and Senior Services, or the MO HealthNet Division within the Department of Social Services in connection with the employee’s official duties including oversight of state health problems, tracking infectious diseases, administering state wellness initiatives and programs, and researching state medical trends. The substitute does not prohibit disclosure of personal health information consistent with federal law and does not require health care providers to obscure or remove the information when disclosing it.

TRANSPARENCY OF HEALTH CARE INFORMATION

Programs of insurers that publicly assess and compare the quality and cost efficiency of health care providers must conform to specified criteria for the transparency of health care information.

Any person who sells or distributes comparative health care quality and cost-efficiency data for public disclosure must identify the measuring technique used to validate and analyze the data, except for articles or research studies published in peer-reviewed academic journals that do not receive funding from a health care insurer or state or local government. Individuals violating this provision will be investigated by the Department of Health and Senior Services and may be subject to a penalty of up to $1,000. Health insurers violating this provision will be investigated by the Department of Insurance, Financial Institutions and Professional Registration and subject to the department's enforcement powers of the state's insurance laws.

PATIENT SAFETY

Beginning January 1, 2010, hospitals must report all serious health care incidents resulting in serious adverse events to a federally designated patient safety organization no later than one business day following the discovery of the incident. The report must describe the immediate actions taken to minimize patient risk and the prevention measures carried out. The hospital will have 45 days after the incident was discovered to submit a root cause analysis report and prevention plan to the organization, with or without the technical assistance of the organization. If the organization finds any of the reports provided by the hospital to be insufficient, the hospital will have two attempts to make corrections. If permitted by the federal Patient Safety and Quality Improvement Act of 2005, the Department of Health and Senior Services will assist hospitals with three or more insufficient reports and accept reports from a hospital that does not submit serious adverse events to an organization. All hospitals must establish policies to notify a patient within one business day after the hospital is aware of an occurrence of a serious adverse event in health care. Notifying the patient will not be considered acknowledgment or admission of hospital liability for the serious adverse event. After receiving a complete root cause analysis report and prevention plan from a hospital, an organization must assess the information and report back to the hospital with its findings and recommendations for preventing future incidents.

By April 30 of every year, the department must publish to the public a report indicating the number of serious adverse events for the previous year by category of reportable incident and rate per patient encounter by region and by category of reportable incident, and by facility region. Hospitals must report incidents of serious adverse events on a quarterly basis to the department.

Patient safety organization meetings with individuals related to an incident must keep discussions limited to the course of carrying out the business of the organization. Proceedings and records of an organization cannot be used in civil action against a health care provider, and providers furnishing services to an organization cannot be liable for civil damages as a result of findings based on the provider’s services.

An organization can disclose non-identifying information regarding the number and type of patient safety incidents that occur, but documents and any communication created by a health care provider must be kept confidential by the organization.

Beginning January 1, 2010, hospitals that report an incident of a

serious adverse event cannot charge for or bill individuals or insurers for services related to the incident. If an insurer denies a claim because of lack of coverage for services that resulted from an incident of a serious adverse event, the health care provider or facility involved cannot bill the patient for the uncovered services.

MISSOURI HEALTH INSURANCE POOL

A Missouri resident who has exhausted his or her maximum benefits from his or her health insurer or can only obtain health insurance from a carrier at a rate that is more expensive than the pool's eligibility rates will be eligible for coverage under the pool. Currently, after December 31, 2009, a person who has health insurance coverage through an insurer and has experienced a premium rate increase of 300% or more of the individual standard rates established by the MHIP Board is eligible to obtain coverage through the pool. The substitute removes this provision.

An individual who has had prior creditable coverage with a group, governmental, or church plan and is not eligible for certain Social Security or Title XIX benefits; does not have other health insurance coverage; and has exhausted continuation of coverage through COBRA will be eligible for coverage under the pool.

All health insurers must notify an insured when he or she has exhausted 85% of his or her total lifetime health insurance benefits and of the person's eligibility for and the methods of applying for coverage under the pool. Notification must be repeated when an insured has exhausted 100% of his or her total lifetime health insurance benefits, and the insurer must also notify the pool with the name and address of the affected person.

The board is required to offer health benefit plans that are in the best interest of the individuals covered under the pool including, but not limited to, coverage for dental, vision, and limited mandate plans or other flexible benefit plans and can establish a premium rate load to allow enrollees to buy down creditable coverage. An individual’s premium rate for the pool must be based on the individual’s family size. The substitute removes the lower limit requirement for pool coverage for applicants. Pool coverage rates cannot exceed 125% of those applicable to individual standard risks for individuals who have had prior creditable coverage with a group, governmental, or church plan; are not eligible for certain Social Security or Title XIX benefits; do not have other health insurance coverage; and have exhausted continuation of coverage through COBRA. Pool coverage rates cannot exceed 125% of rates applicable to individual standard risks for all others covered in the pool.

The pool must establish a premium assistance program, subject to appropriations, for individuals with incomes less than the pool's eligibility limit or who jointly contribute to their premium with their employer. The premium assistance will be based on a sliding income scale, capped at 300% of the federal poverty level, established by the pool along with any cost-sharing requirements, such as deductibles, co-payments, and co-insurance. Any federal or grant funds received for the purpose of premium assistance must be used through the premium assistance program established by the pool.

When implementing the provisions regarding the coverage for pool enrollees and provider payments, the board is required to make sure that the special needs of Missouri's Tier I Safety Net providers are not disproportionately impacted by its rules.

Insurance agents and brokers selling or renewing pool policies will receive a 5% commission.

HEALTH CARRIER NOTIFICATION REQUIREMENTS

The substitute requires all health carriers to notify their enrollees in writing or electronically or by phone when a health care provider changes from an in-network provider to an out-of-network provider. Carriers must notify enrollees at least 30 business days prior to the effective date, or as soon as possible, of the status change and must have a written procedure that ensures continuity of care for enrollees when network status changes occur including notification and transfers to other in-network providers. If a provider changes its network status, the carrier must provide enrollees with continuation of care for up to 90 days when medically necessary and medically prudent. If continuation of care is needed or if the carrier fails to notify an enrollee 30 days prior to any network status change, the enrollee can continue to receive services at in-network costs from the provider who changed to out-of-network status and the enrollee will not be liable for any charges in excess of in-network rates and costs. If the in-network provider who changed network status is authorized to provide continuation of care to an enrollee, the carrier must reimburse the provider at in-network rates.

FISCAL NOTE: Estimated Cost on General Revenue Fund of Unknown but Greater than $304,166 in FY 2010, Unknown but Greater than $325,000 in FY 2011, and Unknown but Greater than $325,000 in FY 2012. No impact on Other State Funds in FY 2010, FY 2011, and FY 2012.

PROPONENTS: Supporters say that because of the third-party payor system, the way in which we consume health care services is

unlike any other services that we consume, meaning that consumers do not seek the best bargain. Obtaining cost and quality health care data is difficult to do. Health care is not rationed on the basis for price; thus, providers do not compete on price or even quality. Utilization, technology, and competency are the drivers of health care costs. Transparency is one thing that we can do at the state level to help Missouri citizens make more informed decisions regarding their health care.

Testifying for the bill were Representative Ervin; Anthem Blue Cross Blue Shield of Missouri; Monsanto Company; Ron Laudel, Carpenters' Health and Welfare Trust Fund of St. Louis; Jim Denning, Discover Vision Center; Mary Jo Feldstein, Business Health Coalition; Associated Industries of Missouri; and Ford Motor Company.

OPPONENTS: Those who oppose the bill say that we need to standardize quality measures which the bill does, but it needs additional provisions in order to implement correctly within the industry. There has to be more separation between regulators and patient safety organizations. The bill does not tell providers the guidelines of how to implement the provisions. The insurers must have uniformity in reporting instead of many individual reports.

Testifying against the bill were BJC Health Care Systems; Washington University; Missouri Association of Osteopathic Physicians and Surgeons; Missouri Hospital Association; Missouri State Medical Association; and Missouri Academy of Family Physicians.