SECOND REGULAR SESSION
HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 856

90TH GENERAL ASSEMBLY

Reported from the Committee on Critical Issues, April 11, 2000, with recommendation that the House Committee Substitute for Senate Bill No. 856 Do Pass.

ANNE C. WALKER, Chief Clerk

3821L.04C

AN ACT

To repeal sections 376.406 and 376.426, RSMo 1994, and sections 198.530, 354.603, 376.383, 376.893, 376.1350, 376.1361, 376.1367, 376.1400 and 376.1403, RSMo Supp. 1999, relating to the regulation of managed care, and to enact in lieu thereof sixteen new sections relating to the same subject.

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

Section A. Sections 376.406 and 376.426, RSMo 1994, and sections 198.530, 354.603, 376.383, 376.893, 376.1350, 376.1361, 376.1367, 376.1400 and 376.1403, RSMo Supp. 1999, are repealed and sixteen new sections enacted in lieu thereof, to be known as sections 198.530, 354.603, 376.383, 376.384, 376.406, 376.419, 376.426, 376.893, 376.895, 376.1350, 376.1361, 376.1367, 376.1405, 376.1406, 376.1408 and 1, to read as follows:

198.530. 1. If an enrollee in a managed care organization is also a resident in a long-term care facility licensed pursuant to chapter 198, or a continuing care retirement community, as defined in section 197.305, RSMo, such enrollee's managed care organization shall provide the enrollee with the option of receiving the covered service in the long-term care facility which serves as the enrollee's primary residence. For purposes of this section, "managed care organization" means any organization that offers any health plan **[**certified**] licensed** by the department of **[**health**] insurance** designed to provide incentives to medical care providers to manage the cost and use of care associated with claims, including, but not limited to, a health maintenance organization **[**and preferred provider organization**], insurance company and health services corporation**. The resident enrollee's managed care organization shall reimburse the resident facility for those services which would otherwise be covered by the managed care organization if the following conditions apply:

(1) The facility is willing and able to provide the services to the resident; and

(2) The facility and those health care professionals delivering services to residents pursuant to this section meet the licensing and training standards as prescribed by law; and

(3) The facility is certified through Medicare; and

(4) The facility and those health care professionals delivering services to residents pursuant to this

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

section agree to abide by the terms and conditions of the health carrier's contracts with similar providers, abide by patient protection standards and requirements imposed by state or federal law for plan enrollees and meet the quality standards established by the health carrier for similar providers.

2. The managed care organization shall reimburse the resident facility at a rate of reimbursement not less than the Medicare allowable rate pursuant to Medicare rules and regulations.

3. The services in subsection 1 of this section shall include, but are not limited to, skilled nursing care, rehabilitative and other therapy services, and postacute care, as needed. Nothing in this section shall limit the managed care organization from utilizing contracted providers to deliver the services in the enrollee's resident facility.

4. A resident facility shall not prohibit a health carrier's participating providers from providing covered benefits to an enrollee in the resident facility. A resident facility or health care professional shall not impose any charges on an enrollee for any service that is ancillary to, a component of, or in support of the services provided under this section when the services are provided by a health carrier's participating provider, or otherwise create a disincentive for the use of the health carrier's participating providers. Any violation of the requirements of this subsection by the resident facility shall be considered abuse or neglect of the resident enrollee.

354.603. 1. A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable delay. In the case of emergency services, enrollees shall have access twenty-four hours per day, seven days per week. The health carrier's medical director shall be responsible for the sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by the director in accordance with the requirements of this section and by reference to any reasonable criteria, including but not limited to, provider-enrollee ratios by specialty, primary care provider-enrollee ratios, geographic accessibility, reasonable distance accessibility criteria for pharmacy and other services, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

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

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

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

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

2. Beginning July 1, 1998, a health carrier shall file with the director, in a manner and form defined by rule of the department of insurance, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing. The access plan shall describe or contain at a minimum the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

(4) The health carrier's methods for assessing the health care needs of enrollees and their satisfaction with services;

(5) The health carrier's method of informing enrollees of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling enrollees to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, in the event of a reduction in service area or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the health carrier's insolvency or other modification or cessation of operations, and transferred to other providers in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 354.600 to 354.636.

376.383. 1. To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section shall apply to any health **[**insurer**] carrier** as defined in section **[**376.806, any nonprofit health service plan and any health maintenance organization**] 376.1350**.

2. Within forty-five days after receipt of a claim for reimbursement **[**from a person entitled to reimbursement**] for a health care service as defined in section 376.1350**, a health **[**insurer, nonprofit health service plan or health maintenance organization**] carrier** shall pay the claim in accordance with this section or send a notice of receipt and status of the claim that states:

(1) That the **[**insurer, nonprofit health service plan or health maintenance organization**] health carrier** refuses to reimburse all or part of the claim and the reason for the refusal; or

(2) That additional information is necessary to determine if all or part of the claim will be

reimbursed and [what] **a complete description of all** specific additional information **that** is necessary **to process the entire claim**.

3. If [an insurer, nonprofit health service plan or health maintenance organization] **a health carrier** fails to comply with subsection 2 of this section, the [insurer, nonprofit health service plan or health maintenance organization] **health carrier** shall pay interest on the amount of the claim that remains unpaid forty-five days after the claim is filed at the monthly rate of one percent. 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.

4. Within ten days after the day on which all additional information is received by [an insurer, nonprofit health service plan or health maintenance organization] **a health carrier**, it shall pay the claim in accordance with this section or send a written notice that:

(1) States refusal to reimburse the claim or any part of the claim; and

(2) Specifies each reason for denial.

[An insurer, nonprofit health service plan or health maintenance organization] **A health carrier** that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the monthly rate of one percent.

5. A provider**, as defined in section 376.1350,** who is paid interest [under] **pursuant to** this section shall pay the proportionate amount of [said] **such** interest to the enrollee or insured to the extent and for the time period that the enrollee or insured had paid for the services and for which reimbursement was due to the insured or enrollee.

6. [This section shall become effective April 1, 1999.] **In addition to other remedies provided by law, a person who has filed a claim for reimbursement for a health care service, as defined in section 376.1350, may file a civil action against the health carrier for any violation of this section. If the court finds that a violation of this section has occurred, the court shall award to a prevailing plaintiff fees and other expenses in addition to the claimed reimbursement and interest, unless the court finds that the position of the health carrier was substantially justified. For purposes of this section, "fees and other expenses" includes reasonable attorney fees, reasonable expenses of expert witnesses or any other cost which is found by the court to be reasonable for the preparation of the plaintiff's case. A plaintiff seeking an award of fees and other expenses shall, within thirty days of a final judgment in a civil action, submit to the court that rendered the final judgment an application which shows that the plaintiff is a prevailing party and is eligible to receive an award pursuant to this section, and the amount sought, including an itemized statement from any attorney or expert witness representing or appearing on behalf of the plaintiff stating the actual time expended and the rate at which fees and other expenses are computed. The plaintiff shall also allege that the position of the defendant was not substantially justified. The fact that the defendant has lost the civil action creates no legal presumption that its position was not substantially justified. Whether the position of the defendant is substantially justified shall be determined on the basis of the record which is made in the civil action for which fees and other expenses are sought.**

376.384. 1. For purposes of this section, "health care provider" or "provider" means a health care professional or facility, and "health carrier" means the same as such term is defined in section 376.1350. Any health carrier shall:

(1) Permit providers to file confirmation numbers of authorized services and claims in the same manner or format;

(2) Permit providers to file claims for reimbursement for a period of up to one year following the provision of a health care service;

(3) Issue within twenty-four hours, by facsimile transmission or other electronic means, confirmation of receiving a claim for reimbursement;

(4) When processing claims, accept all codes, including modifiers, that are included within the physician's current procedural terminology (CPT) of the American Medical Association, as amended; the Health Care Financing Administration's common procedure coding system (HCPCS), as amended; the International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM) system, as amended; Diagnosis Related Group (DRG) coding, as amended; and any additional procedure, diagnosis and treatment codes approved by the department of insurance. The department of insurance shall promulgate rules for the implementation of such standard codes and the approval of additional procedure, diagnosis and treatment codes; and

(5) During contract negotiations with providers and upon delivery of the final contract, provide a current fee schedule for provider reimbursement for all covered services and forward to the provider, at least thirty days in advance of the effective date of such modifications, all modifications to such fee schedule.

2. No health carrier shall request a refund or offset against a claim more than six months after a provider has filed a claim except in cases of fraud or misrepresentation by the provider.

3. All health carriers shall provide access on the Internet to a current provider directory.

4. A health carrier shall inform an enrollee when the carrier denies coverage of a health care service requested to be provided or provided to such enrollee. The health carrier shall explain such denial of coverage in plain language that is easy for a layperson to understand.

5. No rule or portion of a rule promulgated pursuant to the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of chapter 536, RSMo.

376.406. 1. All **[**individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, and all self-insured group health benefit plans, of any type or description,**]** **health benefit plans** which provide coverage for a family member of **[**the insured or subscriber**]** **an enrollee** shall, as to such family member's coverage, also provide that the health **[**insurance**]** benefits applicable for children shall be payable with respect to a newly born child of the **[**insured or subscriber**]** **enrollee** from the moment of birth.

2. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

3. If payment of a specific premium or subscription fee is required to provide coverage for a child, the **[**policy or contract**]** **health benefit plan** may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the **[**insurer or nonprofit service or indemnity corporation**]** **health carrier** within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one day period. **If an application or other form of enrollment is required in order to continue coverage beyond the thirty-one-day period after the date of birth and the**

enrollee has notified the health carrier of the birth, either verbally or in writing, the health carrier shall, upon notification, provide the enrollee with all forms and instructions necessary to enroll the newly born child and shall allow the enrollee an additional thirty-one days from the date the forms and instructions are provided in which to enroll the newly born child.

4. The requirements of this section shall apply to all **[**insurance policies and subscriber contracts**]** **health benefit plans** delivered or issued for delivery in this state **[**more than one hundred twenty days after August 13, 1974**]** **on or after August 28, 2000**.

5. For the purposes of this section, any review, renewal, extension, or continuation of any **[**plan, policy, or contract**]** **health benefit plan** or of any of the terms, premiums, or subscriptions of the **[**plan, policy, or contract**]** **health benefit plan** shall constitute a new delivery or issuance for delivery of the **[**plan, policy or contract**]** **health benefit plan**.

6. As used in this section, the terms "health benefit plan", "health carrier" and "enrollee" shall have the same meaning as defined in section 376.1350.

376.419. 1. As used in this section, the term "hold harmless clause" means a contractual arrangement whereby a health care provider assumes the sole liability inherent in the provision of health care services, thereby relieving an insurer from such liability. For purposes of this section, "health care provider" or "provider" means a health care professional or facility.

2. To the extent consistent with the Employment Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section shall apply to any health carrier, as defined in section 376.1350.

3. No contract between a health care provider and a health carrier entered into after the effective date of this section shall include a hold harmless clause. Any hold harmless clause in an existing contract shall become void on the effective date of this section.

4. No contract between a health care provider and a health carrier entered into after the effective date of this section shall require a licensed health care professional or group of professionals to agree to participate in all health care or managed care plans, or accident and health policies operated by the carrier as a condition for participation in one or more plans or policies offered by the carrier.

5. No contract between a health care provider and a health carrier entered into after the effective date of this section shall require a licensed health care provider or group of providers to participate in lease business if the health carrier leases its provider network to another health carrier, unless such health care provider or group of providers are notified of the proposed lease and agree to such lease.

376.426. No policy of group health insurance shall be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the director of insurance are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder; except that: Provisions in subdivisions (5), (7), (12), (15), and (16) of this section shall not apply to policies insuring debtors; standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy:

(1) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue, and that no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by the person making such statement; except that, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy;

(3) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage;

(5) A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of:

(a) The end of a continuous period of twelve months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; or

(b) The end of the two-year period commencing on the effective date of the person's coverage;

(6) If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of the covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(7) A provision that the insurer shall issue to the policyholder, for delivery to each person insured**[**,**]:**

(a) A certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage;

(b) An enrollee card which includes a telephone number for the plan and a brief

description of the enrollee's type of health care plan. Such description shall include, but not be limited to, terms such as preferred provider organization, point of service, health maintenance organization or indemnity plan;

(8) A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;

(9) A provision that the insurer shall furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made;

(10) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required;

(11) A provision that all benefits payable under the policy other than benefits for loss of time shall be payable not more than thirty days after receipt of proof and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof;

(12) A provision that benefits for accidental loss of life of a person insured shall be payable to the beneficiary designated by the person insured or, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;

(13) A provision that the insurer shall have the right and opportunity, at the insurer's own expense, to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of the claim under the policy and also the right and opportunity, at the insurer's own expense, to make an autopsy in case of death where it is not prohibited by law;

(14) A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration

of the time within which proof of loss is required by the policy;

(15) A provision specifying the conditions under which the policy may be terminated. Such provision shall state that except for nonpayment of the required premium or the failure to meet continued underwriting standards, the insurer may not terminate the policy prior to the first anniversary date of the effective date of the policy as specified therein, and a notice of any intention to terminate the policy by the insurer must be given to the policyholder at least thirty-one days prior to the effective date of the termination. Any termination by the insurer shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received;

(16) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, shall be deemed to provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the policyholder for support and maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the policyholder at least thirty-one days before the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such two-year period, the insurer may require subsequent proof not more than once each year. This subdivision shall apply only to policies delivered or issued for delivery in this state on or after one hundred twenty days after September 28, 1985;

(17) In the case of a policy insuring debtors, a provision that the insurer shall furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness.

376.893. 1. Within sixty days of legal separation or the entry of a decree of dissolution of marriage or prior to the expiration of a thirty-six month federal Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation period covering a legally separated or divorced spouse, if such spouse has elected and maintained such COBRA coverage, a legally separated or divorced spouse eligible for continued coverage **[**under**]** **pursuant to** section 376.892 who seeks such coverage shall give the plan administrator written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse.

2. Within thirty days of the death of a certificate holder whose surviving spouse is eligible for continued coverage **[**under**]** **pursuant to** section 376.892 or prior to the expiration of a thirty-six month federal Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation period covering such surviving spouse, if such spouse has elected and maintained such COBRA coverage, the group policyholder shall give the plan administrator written notice of the death and of the mailing address of the surviving spouse.

3. Within fourteen days of receipt of notice **[**under**]** **pursuant to** subsection 1 or 2 of this section, the plan administrator shall notify the legally separated, divorced or surviving spouse that the policy may be continued. The notice shall be mailed to the mailing address provided to the plan administrator and shall include:

(1) A form for election to continue the coverage;

(2) A statement of the amount of periodic premiums to be charged for the continuation of coverage and of the method and place of payment; **[**and**]**

(3) Instructions for returning the election form by mail within sixty days after the date of mailing of the notice by the plan administrator**; and**

(4) Notice that if insurance is continued the insurer is required to provide both parents of a covered child with coverage information regardless of whether the parent is the primary policyholder pursuant to section 376.895.

4. Failure of the legally separated, divorced or surviving spouse to exercise the election in accordance with subsection 3 of this section shall terminate the right to continuation of benefits.

5. If a plan administrator was properly notified pursuant to the provisions of subsection 1 or 2 of this section and fails to notify the legally separated, divorced or surviving spouse as required by subsection 3 of this section, such spouse's coverage shall continue in effect, and such spouse's obligation to make any premium payment for continuation coverage **[**under**]** **pursuant to** sections 376.891 to 376.894 shall be postponed for the period of time beginning on the date the spouse's coverage would otherwise terminate and ending thirty-one days after the date the plan administrator provides the required notice. Failure or delay by a plan administrator in providing the notice required by this section shall not reduce, eliminate or postpone the plan sponsor's obligation to pay premiums on behalf of such legally separated, divorced or surviving spouse to the plan administrator during such period.

6. The provisions of sections 376.891 to 376.894 apply only to employers with twenty or more employees and any policy, contract or plan with twenty or more certificate holders.

376.895. Any insurer providing coverage for a child with parents who are legally separated or divorced shall provide coverage information regarding such child to both parents regardless of whether the inquiring parent is the primary policyholder.

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

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

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

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

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

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

(9) "Director", the director of the department of insurance;

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

(18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(19) "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

(20) "Health care provider" or "provider", a health care professional or a facility;

(21) "Health care service", a service **or prescription medication** for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

(22) "Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services;

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

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

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

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

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

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

(29) "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

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

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

(32) "Standard reference compendia":

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

(b) The United States Pharmacopoeia-Drug Information;

(33) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent

review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

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

376.1361. 1. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request by either the director of the department of health or the director of the department of insurance.

2. Any medical director who administers the utilization review program or oversees the review decisions shall be a qualified health care professional licensed in the state of Missouri. A licensed clinical peer shall evaluate the clinical appropriateness of adverse determinations.

3. A health carrier shall issue utilization review decisions in a timely manner pursuant to the requirements of sections 376.1363, 376.1365 and 376.1367. A health carrier shall obtain all information required to make a utilization review decision, including pertinent clinical information. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

4. A health carrier's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

5. If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which shall include:

(1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(2) Evidence of formal approval of the utilization review organization program by the health carrier; and

(3) A process by which the health carrier evaluates the performance of the utilization review organization.

6. The health carrier shall coordinate the utilization review program with other medical management activities conducted by the carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for accessing member satisfaction and risk management.

7. A health carrier shall provide enrollees and participating providers with timely access to its review staff by a toll-free number.

8. When conducting utilization review, the health carrier shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency and duration of services.

9. Compensation to persons providing utilization review services for a health carrier shall not contain direct or indirect incentives for such persons to make medically inappropriate review decisions. Compensation to any such persons may not be directly or indirectly based on the quantity or type of adverse determinations rendered.

10. A health carrier shall permit enrollees or a provider on behalf of an enrollee to appeal for the coverage of medically necessary pharmaceutical prescriptions and durable medical equipment as part of the health carriers' utilization review process.

11. (1) This subsection shall apply to:

(a) Any health benefit plan that is issued, amended, delivered or renewed on or after January 1,

1998, and provides coverage for drugs; or

(b) Any person making a determination regarding payment or reimbursement for a prescription drug pursuant to such plan.

(2) A health benefit plan that provides coverage for drugs shall provide coverage for any drug prescribed to treat an indication so long as the drug has been approved by the FDA for at least one indication, if the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature and deemed medically appropriate.

(3) This section shall not be construed to require coverage for a drug when the FDA has determined its use to be contraindicated for treatment of the current indication.

(4) A drug use that is covered pursuant to subsection 1 of this section shall not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use.

(5) Any drug or service furnished in a research trial, if the sponsor of the research trial furnishes such drug or service without charge to any participant in the research trial, shall not be subject to coverage pursuant to subsection 1 of this section.

(6) Nothing in this section shall require payment for nonformulary drugs, except that the state may exclude or otherwise restrict coverage of a covered outpatient drug from Medicaid programs as specified in the Social Security Act, Section 1927(d)(1)(B).

(7) Every health carrier shall notify the pharmacist, primary care physician, prescribing physician and enrollee when:

(a) A nonformulary drug is authorized with conditions, such as an authorization for a limited period of time; or

(b) The health carrier modifies its formulary in a manner that affects the authorization or coverage of a drug that was authorized or covered before such modification.

12. A carrier shall issue a confirmation number to an enrollee when the health carrier, acting through a participating provider or other authorized representative, authorizes the provision of health care services. **Certification of a health care service shall be deemed to be an authorization of a health care service.**

13. If an authorized representative of a health carrier authorizes the provision of health care services, the health carrier shall not subsequently retract its authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless

(1) Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or

(2) The health benefit plan terminates before the health care services are provided; **[**or**]**

(3) The covered person's coverage under the health benefit plan terminates before the health care services are provided**; or**

(4) The covered person's coverage under the health benefit plan has exceeded such person's annual or lifetime benefits limit.

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

(1) A health carrier shall cover emergency services necessary to screen and stabilize an enrollee and shall not require prior authorization of such services;

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

(3) 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**]** **thirty** minutes of receiving a request; if the authorization decision is not made within thirty minutes, such services shall be deemed approved.

376.1405. 1. Every health insurance carrier offering policies of insurance in this state shall use a standardized form for the explanation of benefits given to the health care provider whenever a claim is paid or denied. As used in this section, the term "health insurance carrier" shall have the meaning given to "health carrier" in section 376.1350. Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

2. The standardized form developed by the task force as established in section 376.1408 shall contain the following:

(1) The name of the insured;

(2) The insured's identification number;

(3) The date of service;

(4) Amount of charge;

(5) Explanation for any denial;

(6) The amount paid and any balance due;

(7) The procedure code;

(8) The patient's full name; and

(9) The phone number and name of whom to contact for questions on explanation of benefits.

3. All health insurance carriers shall use the standard explanation of benefits form after January 1, 2002.

376.1406. 1. Every health care provider and health carrier that conducts business in this state shall use a standardized form for referrals. The standardized referral form shall be used in lieu of any specific referral form developed by a health carrier for the referral process. As used in this section, the terms "health care provider" and "health carrier" shall have the meaning given to them in section 376.1350.

2. The referral form developed by the task force as established in section 376.1408 shall contain the following:

(1) The name of the insured;

(2) Place of employment;

(3) The name, address and phone number of the health carrier;

(4) The identification number and group number of the insured;

(5) The type of referral;

(6) The name, address and phone number of the health care provider referring the insured;

(7) The name, address and phone number of the health care provider of whom the insured was referred to;

(8) The number of visits requested and authorized; and

(9) The health carrier's authorization number.

3. All health care providers and health carriers shall use the standardized referral form after January 1, 2002.

376.1408. 1. The department of insurance shall establish a task force to develop the standardized forms required by sections 376.1405 and 376.1406. The task force shall meet for soliciting information to develop the standardized forms. The task force shall consist of the following members:

(1) Three health care providers;

(2) Three representatives from the insurance industry; and

(3) Three members from the general public.

2. No member of the task force shall receive compensation for the performance of duties related to the task force but shall be reimbursed for reasonable and necessary expenses incurred in the performance of such duties.

3. The department of insurance shall have the task force established by January 1, 2001.

Section 1. 1. All managed care organizations, as defined in section 198.530, RSMo, shall allow the enrollee the right to select a long-term care facility licensed pursuant to chapter 198, RSMo, with the same religious orientation as demonstrated by the enrollee. If a religiously appropriate facility is not included in the managed care organization's provider network and one is available, the managed care organization shall provide the enrollee the option to receive care from an out-of-network long-term care facility licensed pursuant to chapter 198, RSMo, or a continuing care community, as defined in section 197.305, RSMo, if the following conditions apply:

(1) The facility is willing and able to provide the services to the resident; and

(2) The facility and those health care professionals delivering services to residents pursuant to this section meet the licensing and training standards as prescribed by law; and

(3) The facility is certified through Medicare; and

(4) The facility and those health care professionals delivering services to residents pursuant to this section agree to abide by the terms and conditions of the managed care organization's contracts with similar providers, abide by patient protection standards and requirements imposed by state or federal law for plan enrollees and meet the quality standards established by the managed care organization for similar providers.

2. The managed care organization shall reimburse the facility at a rate of reimbursement not less than the Medicare allowable rate pursuant to Medicare rules and regulations. In the absence of such a rule or regulation, the managed care organization shall reimburse the facility at a rate not less than the contracted reimbursement rate of similar providers within the managed care organization's provider network.

[376.1400. 1. Every health insurance carrier offering policies of insurance in this state shall use standardized information for the explanation of benefits given to the health care provider whenever a claim is paid or denied. As used in this section, the term "health insurance carrier" shall have the meaning given to "health carrier" in section 376.1350. Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, short- term major medical policies of six months or less duration, other limited benefit health insurance policies.

2. The standardized information shall contain the following:

(1) The name of the insured;

(2) The insured's identification number;

(3) The date of service;

(4) Amount of charge;

(5) Explanation for any denial;

(6) The amount paid;

(7) The patient's full name;

(8) The name and address of the insurer; and

(9) The phone number to contact for questions on explanation of benefits.

3. All health insurance carriers shall use the standard explanation of benefits information after January 1, 2002.**]**

[376.1403. 1. Every health care provider and health carrier that conducts business in this state shall use standardized information for referrals. As used in this section, the terms "health care provider" and "health carrier" shall have the meaning given to such terms in section 376.1350.

2. The referral information shall contain the following:

(1) The name of the insured;

(2) The name, address and phone number of the health carrier;

(3) The identification number and group number of the insured;

(4) The type of referral;

(5) The name, address and phone number of the health care provider referring the insured;

(6) The name, address and phone number of the health care provider to whom the insured was referred to;

(7) The number of visits requested and authorized; and

(8) The health carrier's authorization number.

3. All health care providers and health carriers shall use the standardized referral information after January 1, 2002.**]**