FIRST REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILLS NOS. 391 & 395

91ST GENERAL ASSEMBLY

Reported from the Committee on Insurance and Housing, February 15, 2001, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

1620S.03C

AN ACT

To repeal sections 354.603, 354.618, 376.383, 376.406 and 376.893, RSMo 2000, relating to reimbursement for health care services, and to enact in lieu thereof eight new sections relating to the same subject.

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

Section A. Sections 354.603, 354.618, 376.383, 376.406 and 376.893, RSMo 2000, are repealed and eight new sections enacted in lieu thereof, to be known as sections 354.603, 354.618, 376.383, 376.384, 376.406, 376.419, 376.893 and 376.895, to read as follows:

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,

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

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 received one 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 **health** 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 **health** 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.

354.618. 1. A health carrier shall be required to offer as an additional health plan, an open referral health plan whenever it markets a gatekeeper group plan as an exclusive or full replacement health plan offering to a group contract holder:

(1) In the case of group health plans offered to employers of fifty or fewer employees, the decision to accept or reject the additional open referral plan offering shall be made by the group contract holder. For health plans marketed to employers of over fifty employees, the decision to accept or reject shall be made by the employee;

(2) Contracts currently in existence shall offer the additional open referral health plan at the next annual renewal after August 28, 1997; however, multiyear group contracts need not comply until the expiration of their current multiyear term unless the group contract holder elects to comply before that time;

(3) If an employer provides more than one health plan to its employees and at least one is an open referral plan, then all health benefit plans offered by such employer shall be exempt from the requirements of this section.

2. For the purposes of this **[**act**]** **section**, the following terms shall mean:

(1) "Open referral plan", a plan in which the enrollee is allowed to obtain treatment for covered benefits without a referral from a primary care physician from any person licensed to provide such treatment;

(2) "Gatekeeper group plan", a plan in which the enrollee is required to obtain a referral from a primary care professional in order to access specialty care.

3. Any health benefit plan provided pursuant to the Medicaid program shall be exempt from the requirements of this section.

4. **[**A health carrier shall have a procedure by which a female enrollee may seek the health care services of an obstetrician/gynecologist at least once a year without first obtaining prior approval from the enrollee's primary care provider if the benefits are covered under the enrollee's

health benefit plan, and the obstetrician/gynecologist is a member of the health carrier's network.**]** **A health carrier shall not require as a condition to the coverage of the services of a participating obstetrician or a participating gynecologist that a covered person first obtain a referral from a primary care provider. The covered person shall, at all times, have direct access to the services of a participating obstetrician or a participating gynecologist of her choice within the provider network. For purposes of this subsection, an obstetrician or gynecologist is defined as a physician licensed pursuant to chapter 334, RSMo, and is board eligible or board certified by the American Board of Obstetricians and Gynecologists. The services covered by this subsection shall be limited to those services defined by the published recommendations of the accreditation council for graduate medical education for training an obstetrician or gynecologist, including, but not limited to, diagnosis, treatment and referral. A health carrier shall not impose a surcharge, or additional co-payments or deductibles upon any covered person who seeks or receives covered health care services pursuant to this subsection, unless similar surcharges, or additional co-payments or deductibles are imposed for other types of covered health care services received within the network.** In no event shall a health carrier be required to permit an enrollee to have health care services delivered by a nonparticipating obstetrician/gynecologist. An obstetrician/gynecologist who delivers health care services directly to an enrollee shall report such visit and health care services provided to the enrollee's primary care provider. **[**A health carrier may require an enrollee to obtain a referral from the primary care physician, if such enrollee requires more than one annual visit with an obstetrician/gynecologist.**]**

5. Except for good cause, a health carrier shall be prohibited either directly, or indirectly through intermediaries, from discriminating between eye care providers when selecting among providers of health services for enrollment in the network and when referring enrollees for health services provided within the scope of those professional licenses and when reimbursing amounts for covered services among persons duly licensed to provide such services. For the purposes of this section, an eye care provider may be either an optometrist licensed pursuant to chapter 336, RSMo, or a physician who specializes in opthamologic medicine, licensed pursuant to chapter 334, RSMo.

6. Nothing contained in this section shall be construed as to require a health carrier to pay for health care services not provided for in the terms of a health benefit plan.

7. Any health carrier, which is sponsored by a federally qualified health center and is presently in existence and which has been in existence for less than three years shall be exempt from this section for a period not to exceed two years from August 28, 1997.

8. A health carrier shall not be required to offer the direct access rider for a group contract holder's health benefit plan if the health benefit plan is being provided pursuant to the terms of a collective bargaining agreement with a labor union, in accordance with federal law and the labor

union has declined such option on behalf of its members.

9. Nothing in this [act] **section** shall be construed to preempt the employer's right to select the health care provider pursuant to section 287.140, RSMo, in a case where an employee incurs a work-related injury covered by the provisions of chapter 287, RSMo.

10. Nothing contained in this [act] **section** shall apply to certified managed care organizations while providing medical treatment to injured employees entitled to receive health benefits [under] **pursuant to the provisions of** chapter 287, RSMo, pursuant to contractual arrangements with employers, or their insurers, [under] **pursuant to** section 287.135, RSMo.

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. For purposes of this section, a "clean claim" shall be defined as a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim pursuant to this section.**

2. Within forty-five days after receipt of a claim for reimbursement [from a person entitled to reimbursement] **for a health care service provided in this state as defined in section 376.1350**, a health [insurer, nonprofit health service plan or health maintenance organization] **carrier** shall pay the **clean** 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) **Until April 1, 2002,** that additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information **that** is necessary**; or**

(3) On or after April 1, 2002, that additional information is necessary to determine if all or part of the claim will be reimbursed and a complete description of all specific additional information that is necessary to process the entire claim as a clean 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. **A carrier may combine interest payments and make payment once the aggregated amount reaches five dollars.**

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, 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**] health care professional, 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.**] On or after April 1, 2002, a health care professional, as defined in section 376.1350 shall file all claims for reimbursement from a health carrier, as defined in section 376.1350, using the HCFA 1500 universal form, and a health carrier shall only accept as a clean claim a claim submitted using the HCFA 1500 universal form.**

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

(1) Permit non-participating health care professionals to file a claim for reimbursement for a health care service provided in this state as defined in section 376.1350 for a period of up to one year from the date of service;

(2) Permit participating health care professionals to file a claim for reimbursement for a health care service provided in this state as defined in section 376.1350 for a period of up to six months from the date of service, unless the contract between the health carrier and health care professional specifies a different standard;

(3) Not request a refund or offset against a claim more than twelve months after a carrier has paid a claim except in cases of fraud or misrepresentation by the health care professional;

(4) Issue within twenty-four hours a confirmation of receipt of an electronically filed claim.

2. On or after January 1, 2003, all claims for reimbursement for a health care service provided in this state as defined in section 376.1350, shall be submitted in an electronic format consistent with federal administrative simplification standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996. Any claim submitted after January 1, 2003, in a non-electronic format shall not be subject to the provisions of section 376.383.

3. The director of the department of insurance shall appoint a task force, to be

comprised equally of health care professionals and health carriers, to develop industry standards for electronic data interchanges that act as clearinghouses for the submission and processing of claims for reimbursement for health care services provided in this state as defined in section 376.1350.

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 ten 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, 2001**.

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 except that nothing in this section shall be construed to apply to any clause in the contract prohibiting providers from balance billing the enrollee or his or her family for any amount in excess of the amount provided for in the contract between the provider and the health carrier. For purposes of this section, "health care provider" or "provider" means a health care professional or facility.

2. 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 carrier, as defined in section 376.1350.

3. Any contract between a health care provider and a health carrier entered into after the effective date of this section shall include a clause that states that each party shall be responsible for any and all claims, liabilities, damages or judgments which may arise as a result of its own negligence or intentional wrongdoing. Each party signatory to the contract shall hold harmless and indemnify the other party against any claims, liabilities, damages or judgments which may be asserted against, imposed upon or incurred by the other party as a result of the first party's negligence or intentional wrongdoing.

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 upon request 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 upon request coverage information regarding such child to both parents regardless of whether the inquiring parent is the primary policyholder.