FIRST REGULAR SESSION

SENATE BILL NO. 313

91ST GENERAL ASSEMBLY

INTRODUCED BY SENATOR CASKEY.

Read 1st time January 17, 2001, and 1,000 copies ordered printed.

TERRY L. SPIELER, Secretary.

1323L.01I

AN ACT

To repeal section 354.400, RSMo 2000, relating to health insurance, and to enact in lieu thereof four new sections relating to the same subject.

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

Section A. Section 354.400, RSMo 2000, is repealed and four new sections enacted in lieu thereof, to be known as sections 354.400, 354.640, 376.1230 and 376.1231, to read as follows:

354.400. As used in sections 354.400 to 354.535, the following terms shall mean:

(1) "Basic health care services", health care services which an enrolled population might reasonably require in order to be maintained in good health, including, as a minimum, emergency care, inpatient hospital and physician care**, as defined in chapter 334, RSMo, and chiropractic physician, as defined in chapter 331, RSMo**, and outpatient medical **and chiropractic** services;

(2) "Community-based health maintenance organization", a health maintenance organization which:

(a) Is wholly owned and operated by hospitals, hospital systems, physicians, or other health care providers or a combination thereof who provide health care treatment services in the service area described in the application for a certificate of authority from the department of insurance;

(b) Is operated to provide a means for such health care providers to market their services directly to consumers in the service area of the health maintenance organization;

(c) Is governed by a board of directors that exercises fiduciary responsibility over the operations of the health maintenance organization and of which a majority of the directors consist of equal numbers of the following:

a. Physicians licensed pursuant to chapter 334, RSMo;

b. Purchasers of health care services who live in the health maintenance organization's service area;

c. Enrollees of the health maintenance organization elected by the enrollees of such organization; and

d. Hospital executives, if a hospital is involved in the corporate ownership of the health maintenance organization;

(d) Provides for utilization review, as defined in section 374.500, RSMo, under the auspices of a physician medical director who practices medicine in the service area of the health maintenance organization, using review standards developed in consultation with physicians who treat the health maintenance organization's enrollees;

(e) Is actively involved in attempting to improve performance on indicators of health status in the community or communities in which the health maintenance organization is operating, including the health status of those not enrolled in the health maintenance organization;

(f) Is accountable to the public for the cost, quality and access of health care treatment services and for the effect such services have on the health of the community or communities in which the health maintenance organization is operating on a whole;

(g) Establishes an advisory group or groups comprised of enrollees and representatives of community interests in the service area to make recommendations to the health maintenance organization regarding the policies and procedures of the health maintenance organization;

(h) Enrolls fewer than fifty thousand covered lives;

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

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

(5) "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 health and medicine, 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;

(6) "Emergency services", health care items and services furnished or required to screen and stabilize 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;

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

(8) "Evidence of coverage", any certificate, agreement, or contract issued to an enrollee setting out the coverage to which the enrollee is entitled;

(9) "Health care services", any services included in the furnishing to any individual of medical**, chiropractic** or dental care or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability;

(10) "Health maintenance organization", any person which undertakes to provide or arrange for basic and supplemental health care services to enrollees on a prepaid basis, or which meets the requirements of section 1301 of the United States Public Health Service Act;

(11) "Health maintenance organization plan", any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of such arrangement consists of providing and assuring the availability of basic health care services to enrollees, as distinguished from mere indemnification against the cost of such services, on a prepaid basis through insurance or otherwise, and as distinguished from the mere provision of service benefits under health service corporation programs;

(12) "Individual practice association", a partnership, corporation, association, or other legal entity which delivers or arranges for the delivery of health care services and which has entered into a services arrangement with persons who are licensed to practice medicine, osteopathy, dentistry, chiropractic, pharmacy, podiatry, optometry, or any other health profession and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide:

(a) That such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(b) To the extent feasible for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff;

(13) "Medical group/staff model", a partnership, association, or other group:

(a) Which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, chiropractors, pharmacists, optometrists, and podiatrists) as are necessary for the provisions of health services for which the group is responsible;

(b) A majority of the members of which are licensed to practice medicine or osteopathy; and

(c) The members of which (i) as their principal professional activity over fifty percent

individually and as a group responsibility engaged in the coordinated practice of their profession for a health maintenance organization; (ii) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other plan, or are salaried employees of the health maintenance organization; (iii) share medical and other records and substantial portions of major equipment and of professional, technical, and administrative staff; (iv) establish an arrangement whereby an enrollee's enrollment status is not known to the member of the group who provides health services to the enrollee;

(14) "Person", any partnership, association, or corporation;

(15) "Provider", any physician, hospital, or other person which is licensed or otherwise authorized in this state to furnish health care services;

(16) "Uncovered expenditures", the costs of health care services that are covered by a health maintenance organization, but that are not guaranteed, insured, or assumed by a person or organization other than the health maintenance organization, or those costs which a provider has not agreed to forgive enrollees if the provider is not paid by the health maintenance organization.

354.640. 1. All managed care organizations subject to the provisions of sections 354.400 to 354.636 shall provide benefits to a covered enrollee who utilizes the services of a chiropractic physician, as defined in chapter 331, RSMo, by self-referral for twenty-four visits under the following conditions:

(1) A covered enrollee may utilize the services of a doctor of chiropractic without discrimination relative to access and fees subject to the terms and conditions of the policy;

(2) Within ten working days of the first visit or consultation, the doctor of chiropractic shall send to the managed care organization, or its designee, the chiropractic case findings. Such findings shall be sufficient documentation for the initial twenty-four visits;

(3) After twenty-four self-referral visits, a covered enrollee who is continuing chiropractic care may be subject to utilization review from the health plan, or its designee, for the purpose of continued care. A provider of the same specialty shall be consulted when making any utilization review determination pursuant to this section;

(4) If the chiropractic provider recommends care beyond twenty-four visits, the participating doctor of chiropractic shall send to the managed care organization, or its designee, documentation containing information on the covered enrollee's progress and necessity of care as well as a care plan for extended chiropractic care. The care recommendation shall be deemed authorized if the managed care organization does not respond to the care recommendation within seven business days. If the doctor of chiropractic fails to provide the required documentation, the insured or its covered enrollee shall not be liable to the chiropractic provider for any unpaid fees;

(5) The covered enrollee shall retain the right to choose chiropractic care on an elective, self-pay, fee-for-service basis. No entity regulated pursuant to this chapter shall prohibit a doctor of chiropractic from continuing care on such basis.

2. Unless otherwise provided for by the managed care organization, self-referral visits shall not apply to wellness care visits.

3. Nothing in this section shall be construed to limit the health plan's ability to credential providers or be deemed as an any willing provider provision.

376.1230. 1. Every policy issued by a health carrier, as defined in section 376.1350, that includes coverage for physician services in the physician's office and every policy that provides major medical or similar comprehensive coverage, including managed care organizations, shall provide chiropractic care as part of basic health care services.

(1) For plans offered by all health carriers, as defined in section 376.1350, a covered enrollee who wishes to receive chiropractic care shall be afforded the opportunity to select a participating provider from a written list of participating chiropractors, as defined in chapter 331, RSMo, by the policy issuers.

(2) A covered enrollee shall have the right to obtain clinically necessary and appropriate initial and follow-up chiropractic care and referrals for diagnostic testing related to chiropractic care without prior approval. The chiropractic services shall be within the scope of practice of the selected doctor of chiropractic.

2. At the time of enrollment and upon request thereafter, the health carriers shall notify each covered enrollee directly or, in the case of a group policy, through the employer that chiropractic care benefits are available under such enrollee's plan.

3. No health carrier utilizing a gatekeeper shall permit such gatekeeper to intentionally misinform a covered enrollee of the existence or availability of chiropractic care benefits under such enrollee's plan.

4. Nothing in this section shall be construed to limit the health carrier's ability to credential providers or be deemed as an any willing provider provision.

376.1231. 1. For purposes of this section, "health care provider" or "provider" means a chiropractic physician licensed pursuant to chapter 331, RSMo, a medical physician or surgeon licensed pursuant to chapter 334, RSMo, or a dentist licensed pursuant to chapter 332, RSMo. Any health carrier, as defined in section 376.1350, shall:

(1) Reimburse health care providers equally for the same or similar services performed within the scope of their practice; and

(2) Not discriminate against any health care provider or group of providers based on licensure, or limit or restrict the diagnosis, treatment or management of the same or similar condition, injury, complaint, disorder or ailment while acting within the

scope of their practice.

2. All health care providers may be subject to reasonable deductibles, co-payment and coinsurance amounts, fee or benefit limits, practice parameters and reasonable utilization review; provided that any such amounts, limits and review shall not function to direct treatment in a manner which unfairly discriminates against any health care providers and shall be no more restrictive than those applicable under the same policy of care or services provided by other health care providers in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments, even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment.