SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILLS NOS. 1061 & 1062

91ST GENERAL ASSEMBLY

Reported from the Committee on Insurance and Housing, February 25, 2002, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

4204S.09C

AN ACT

To repeal sections 354.085, 354.405 and 354.603, RSMo, and to enact in lieu thereof four new sections relating to health insurance administrative simplification.

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

Section A. Sections 354.085, 354.405 and 354.603, RSMo, are repealed and four new sections enacted in lieu thereof, to be known as sections 354.085, 354.405, 354.603 and 376.1450, to read as follows:

354.085. No corporation subject to the provisions of sections 354.010 to 354.380 shall deliver or issue for delivery in this state a form of membership contract, or any endorsement or rider thereto, until a copy of the form shall have been approved by the director. The director shall not approve any policy forms which are not in compliance with the provisions of sections 354.010 to 354.380 of this state, or which contain any provision which is deceptive, ambiguous or misleading, or which do not contain such words, phraseology, conditions and provisions which are specific, certain and reasonably adequate to meet needed requirements for the protection of those insured. If a policy form is disapproved, the reasons therefor shall be stated in writing; a hearing shall be granted upon such disapproval, if so requested; provided, however, that such hearing shall be held no sooner than fifteen days following the request. The failure of the director of insurance to take action approving or disapproving a submitted policy form within **[**thirty**]** **forty-five** days from the date of filing shall be deemed an approval thereof **[**until such time as the director of insurance shall notify the submitting company, in writing, of his disapproval**]**. **The director may not disapprove any deemed policy form for a period of twelve months thereafter. If at any time during that twelve-month period the director**

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

determines that any provision of the deemed policy form is contrary to statute, the director shall notify the health maintenance organization of the specific provision that is contrary to statute, and the specific statute to which the provision is contrary to, and request that the health maintenance organization file, within thirty days of receipt of the request, an amendment form that modifies the provision to conform to the statute. Upon approval of the amendment form by the director, the health maintenance organization shall issue a copy of the amendment to each individual and entity to which the deemed policy form was previously issued and shall attach a copy of the amendment to the deemed policy form when it is subsequently issued. The director of insurance shall have authority to make such reasonable rules and regulations concerning the filing and submission of such policy forms as are necessary, proper or advisable.

354.405. 1. Notwithstanding any law of this state to the contrary, any person may apply to the director for a certificate of authority to establish and operate a health maintenance organization in compliance with this act. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority pursuant to sections 354.400 to 354.636. A foreign corporation may qualify pursuant to sections 354.400 to 354.636, subject to its registration to do business in this state as a foreign corporation pursuant to chapter 351, RSMo, and compliance with the provisions of sections 354.400 to 354.636.

2. Every health maintenance organization doing business in this state on September 28, 1983, shall submit an application for a certificate of authority pursuant to subsection 3 of this section within one hundred twenty days of September 28, 1983. Each such applicant may continue to operate until the director acts upon the application. In the event that an application is not submitted or is denied pursuant to section 354.410, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked. Any health maintenance organization licensed by the department of insurance prior to September 28, 1983, and complying with the paid-in capital or guarantee fund requirements of section 354.410 shall be issued a certificate of authority upon filing an amended certificate of authority and an amended articles of incorporation that conform with sections 354.400 to 354.636. When the annual statement of a health maintenance organization subject to the provisions of sections 354.400 to 354.636 is filed and all fees due from the health maintenance organization are tendered, the health maintenance organization's certificate of authority to do business in this state shall automatically be extended pending formal renewal by the director, or until such time as the director should refuse to renew the certificate.

3. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the director, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant such as the articles of

incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if the applicant is a corporation, and the partners or members if the applicant is a partnership or association;

(4) A copy of any contract made or to be made between any providers and persons listed in subdivision (3) of this subsection and the applicant;

(5) A copy of the form of evidence of coverage to be issued to the enrollees;

(6) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement shall be deemed to satisfy this requirement unless the director directs that additional or more recent financial information is required for the proper administration of sections 354.400 to 354.636;

(8) A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding;

(9) If the applicant is not domiciled in this state, a power of attorney duly executed by such applicant appointing the director, the director's successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(10) A statement reasonably describing the geographic area or areas to be served;

(11) A description of the complaints procedures to be utilized as required by section 354.445;

(12) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation;

(13) Evidence demonstrating that the health maintenance organization has provided its enrollees with adequate access to health care providers; and

(14) Such other information as the director may require to make the determinations required in section 354.410.

4. Every health maintenance organization shall file with the director notice of its

intention to modify any of the procedures or information described in and required to be filed by this section. Such changes shall be filed with the director prior to the actual modification. If the director does not disapprove the modification within **[**thirty**]** **forty-five** days of filing**[**, such modification shall be deemed approved**]**. **If a filing that is deemed approved is a document described in subdivision (4), (5) or (6) of subsection 3 of this section, the director may not disapprove the deemed filing for a period of twelve months thereafter. If at any time during that twelve-month period the director determines that any provision of the deemed filing is contrary to statute, the director shall notify the health maintenance organization of the specific provision that is contrary to statute, and the specific statute to which the provision is contrary to, and request that the health maintenance organization file, within thirty days of receipt of the request, an amendment form that modifies the provision to conform to the statute. Upon approval of the amendment form by the director, the health maintenance organization shall issue a copy of the amendment to each individual and entity to which the deemed filing was previously issued and shall attach a copy of the amendment to the deemed filing when it is subsequently issued.**

5. A health maintenance organization shall file all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto shall be filed and approved.

6. When the director deems it appropriate, the director may exempt any item from the filing requirements of this section.

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, 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 health care provider to submit copies of such health care provider's income tax returns to a health carrier. A health carrier may require a health care provider to obtain audited financial statements if such health care provider received 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. 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 health care professionals 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.

3. In reviewing an access plan filed pursuant to subsection 2 of this section, the director shall deem a managed care plan's network to be adequate if it meets one or more of the following criteria:

(1) The managed care plan is a Medicare + Choice coordinated care plan offered by the health carrier pursuant to a contract with the federal centers for Medicare and Medicaid services;

(2) The managed care plan is being offered by a health carrier that has been accredited by the national committee for quality assurance at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed; or

(3) The managed care plan's network has been accredited by the joint commission on the accreditation of health organizations at a level of "accreditation without type I recommendations" or better, and such accreditation is in effect at the time the access plan is filed. If the accreditation applies to only a portion of the managed care plan's network, only the accredited portion will be deemed adequate.

376.1450. An enrollee, as defined in section 376.1350, may waive his or her right to receive documents and materials from a managed care entity in printed form so long as such documents and materials are readily accessible electronically through the entity's Internet site. An enrollee may revoke such waiver at any time by notifying the managed care entity by phone or in writing. Any enrollee who does not execute such a waiver and prospective enrollees shall have documents and materials from the managed care entity provided in printed form. For purposes of this section, "managed care entity" includes, but is not limited to, a health maintenance organization, preferred provider organization, point of service organization and any other managed health care delivery entity of any type or description.

T