FIRST REGULAR SESSION

SENATE BILL NO. 459

92ND GENERAL ASSEMBLY

INTRODUCED BY SENATOR LOUDON.

Read 1st time February 10, 2003, and 1,000 copies ordered printed.

TERRY L. SPIELER, Secretary.

1301S.01I

AN ACT

To repeal section 354.603, RSMo, and to enact in lieu thereof one new section relating to sufficiency of health insurance networks.

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

Section A. Section 354.603, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 354.603, to read as follows: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, 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.