

FIRST REGULAR SESSION
[PERFECTED]
HOUSE SUBSTITUTE FOR
HOUSE COMMITTEE SUBSTITUTE FOR
HOUSE BILLS NOS. 328 & 88
91ST GENERAL ASSEMBLY

Taken up for Perfection February 14, 2001.

House Substitute for House Committee Substitute for House Bills Nos. 328 & 88, ordered Perfected and printed, as amended.

TED WEDEL, Chief Clerk

0691L.03P

AN ACT

To repeal sections 198.530, 354.535, 354.618, 376.383, 376.406, 376.893, 376.1350, 376.1361, 376.1367, 376.1400 and 376.1403, RSMo 2000, relating to the regulation of managed care, and to enact in lieu thereof seventeen new sections relating to the same subject.

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

Section A. Sections 198.530, 354.535, 354.618, 376.383, 376.406, 376.893, 376.1350, 2 376.1361, 376.1367, 376.1400 and 376.1403, RSMo 2000, are repealed and seventeen new 3 sections enacted in lieu thereof, to be known as sections 198.530, 354.535, 354.604, 354.618, 4 376.383, 376.384, 376.406, 376.419, 376.893, 376.895, 376.1350, 376.1361, 376.1367, 5 376.1405, 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 2 long-term care facility licensed pursuant to chapter 198, or a continuing care retirement 3 community, as defined in section 197.305, RSMo, such enrollee's managed care organization 4 shall provide the enrollee with the option of receiving the covered service in the long-term care 5 facility which serves as the enrollee's primary residence. For purposes of this section, "managed 6 care organization" means any [organization that offers any health plan certified] **entity licensed** 7 by the department of [health] **insurance that offers any health plans** designed to provide 8 incentives to medical care providers to manage the cost and use of care associated with claims,

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

9 including, but not limited to, a health maintenance organization [and preferred provider
10 organization], **insurance company and health services corporation**. The resident enrollee's
11 managed care organization shall reimburse the resident facility for those services which would
12 otherwise be covered by the managed care organization if the following conditions apply:

- 13 (1) The facility is willing and able to provide the services to the resident; and
14 (2) The facility and those health care professionals delivering services to residents
15 pursuant to this section meet the licensing and training standards as prescribed by law; and
16 (3) The facility is certified through Medicare; and
17 (4) The facility and those health care professionals delivering services to residents
18 pursuant to this section agree to abide by the terms and conditions of the health carrier's contracts
19 with similar providers, abide by patient protection standards and requirements imposed by state
20 or federal law for plan enrollees and meet the quality standards established by the health carrier
21 for similar providers.

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

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

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

354.535. 1. If a pharmacy, operated by or contracted with by a [health maintenance
2 organization] **health carrier**, is closed or is unable to provide health care services to an enrollee
3 in an emergency, a pharmacist may take an assignment of such enrollee's right to reimbursement,
4 if the policy or contract provides for such reimbursement, for those goods or services provided
5 to an enrollee of a [health maintenance organization] **health carrier**. No [health maintenance
6 organization] **health carrier** shall refuse to pay the pharmacist any payment due the enrollee
7 under the terms of the policy or contract.

8 2. No [health maintenance organization] **health carrier**, conducting business in the state
9 of Missouri, shall contract with a pharmacy, pharmacy distributor or wholesale drug distributor,

10 nonresident or otherwise, unless such pharmacy or distributor has been granted a permit or
11 license from the Missouri board of pharmacy to operate in this state.

12 3. Every [health maintenance organization] **health carrier** shall apply the same
13 coinsurance, co-payment and deductible factors to all drug prescriptions filled by a pharmacy
14 provider who participates in the [health maintenance organization's] **health carrier's** network
15 if the provider meets the contract's explicit product cost determination. If any such contract is
16 rejected by any pharmacy provider, the [health maintenance organization] **health carrier** may
17 offer other contracts necessary to comply with any network adequacy provisions of this act.
18 However, nothing in this section shall be construed to prohibit the [health maintenance
19 organization] **health carrier** from applying different coinsurance, co-payment and deductible
20 factors between generic and brand name drugs.

21 4. [Health maintenance organizations] **Health carriers** shall not set a limit on the
22 quantity of drugs which an enrollee may obtain at any one time with a prescription, unless such
23 limit is applied uniformly to all pharmacy providers in the [health maintenance organization's]
24 **health carrier's** network.

25 5. [Health maintenance organizations] **Health carriers** shall not insist or mandate any
26 physician or other licensed health care practitioner to change an enrollee's maintenance drug
27 unless the provider and enrollee agree to such change. For the purposes of this provision, a
28 maintenance drug shall mean a drug prescribed by a practitioner who is licensed to prescribe
29 drugs, used to treat a medical condition for a period greater than thirty days. Violations of this
30 provision shall be subject to the penalties provided in section 354.444. Notwithstanding other
31 provisions of law to the contrary, [health maintenance organizations] **health carriers** that change
32 an enrollee's maintenance drug without the consent of the provider and enrollee shall be liable
33 for any damages resulting from such change. Nothing in this subsection, however, shall apply
34 to the dispensing of generically equivalent products for prescribed brand name maintenance
35 drugs as set forth in section 338.056, RSMo.

**354.604. The provisions of section 354.603, subsection 1, subdivision (3), shall not
2 be construed to require any provider to submit copies of such provider's income tax
3 returns to a health carrier. A health carrier may require a provider to obtain audited
4 financial statements if such provider received ten percent or more of the total medical
5 expenditures made by the health carrier.**

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

4 (1) In the case of group health plans offered to employers of fifty or fewer employees,
5 the decision to accept or reject the additional open referral plan offering shall be made by the

6 group contract holder. For health plans marketed to employers of over fifty employees, the
7 decision to accept or reject shall be made by the employee;

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

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

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

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

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

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

23 4. [A health carrier shall have a procedure by which a female enrollee may seek the
24 health care services of an obstetrician/gynecologist at least once a year without first obtaining
25 prior approval from the enrollee's primary care provider if the benefits are covered under the
26 enrollee's health benefit plan, and the obstetrician/gynecologist is a member of the health carrier's
27 network.] **A health carrier shall not require as a condition to the coverage of the services
28 of a participating obstetrician, participating gynecologist or participating
29 obstetrician/gynecologist that a covered person first obtain a referral from a primary care
30 provider. The covered person shall, at all times, have direct access to the services of a
31 participating obstetrician, participating gynecologist or participating
32 obstetrician/gynecologist of her choice within the provider network. For purposes of this
33 subsection, an obstetrician, gynecologist or obstetrician/gynecologist is defined as a
34 physician licensed pursuant to chapter 334, RSMo, and is board eligible or board certified
35 by the American Board of Obstetricians and Gynecologists. The services covered by this
36 subsection shall be limited to those services defined by the published recommendations of
37 the accreditation council for graduate medical education for training an obstetrician,
38 gynecologist or obstetrician/gynecologist, including, but not limited to, diagnosis, treatment
39 and referral. A health carrier shall not impose a surcharge, or additional co-payments or
40 deductibles upon any covered person who seeks or receives health care services pursuant
41 to this subsection, unless similar surcharges, or additional co-payments or deductibles are**

42 **imposed for other types of health care services received within the network. Nothing in**
43 **this subsection shall be construed to conflict with section 376.805, RSMo.** In no event shall
44 a health carrier be required to permit an enrollee to have health care services delivered by a
45 nonparticipating obstetrician/gynecologist. [An obstetrician/gynecologist who delivers health
46 care services directly to an enrollee shall report such visit and health care services provided to
47 the enrollee's primary care provider. A health carrier may require an enrollee to obtain a referral
48 from the primary care physician, if such enrollee requires more than one annual visit with an
49 obstetrician/gynecologist.]

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

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

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

63 8. A health carrier shall not be required to offer the [direct access rider] **open referral**
64 **plan** for a group contract holder's health benefit plan if the health benefit plan is being provided
65 pursuant to the terms of a collective bargaining agreement with a labor union, in accordance with
66 federal law and the labor union has declined such option on behalf of its members.

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

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

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

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

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

12 (2) **Until April 1, 2002**, that additional information is necessary to determine if all or
13 part of the claim will be reimbursed and what specific additional information **that** is necessary;
14 **or**

15 (3) **On or after April 1, 2002, that additional information is necessary to determine**
16 **if all or part of the claim will be reimbursed and a complete description of all specific**
17 **additional information that is necessary to process the entire claim.**

18 3. If [an insurer, nonprofit health service plan or health maintenance organization] **a**
19 **health carrier** fails to comply with subsection 2 of this section, the [insurer, nonprofit health
20 service plan or health maintenance organization] **health carrier** shall pay interest on the amount
21 of the claim that remains unpaid forty-five days after the claim is filed at the monthly rate of one
22 percent. The interest paid pursuant to this subsection shall be included in any late reimbursement
23 without the necessity for the person that filed the original claim to make an additional claim for
24 that interest. **A carrier may combine interest payments and make payment once the**
25 **aggregated amount reaches five dollars.**

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

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

30 (2) Specifies each reason for denial.
31

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

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

39 6. [This section shall become effective April 1, 1999.] **In addition to other remedies**
40 **provided by law, a person who has filed a claim for reimbursement for a health care**

41 service, as defined in section 376.1350, may file a civil action against the health carrier for
42 any violation of this section; provided that such person may not file a civil action until the
43 tenth day following the receipt by the health carrier of a certified letter notifying the health
44 carrier of such person's intention to file a civil action pursuant to this section. Such notice
45 must include the information previously submitted on the claim for reimbursement. No
46 civil action may be filed on any claim and interest paid within the ten-day grace period.
47 If the court finds that a violation of this section has occurred, the court shall award to a
48 prevailing plaintiff a penalty of fifty dollars per day beginning ten days following the date
49 that interest pursuant to this section first becomes due, in addition to the claimed
50 reimbursement and interest. Notwithstanding the provisions of section 507.070 or any
51 other law or rule of court authorizing class actions, no civil action filed pursuant to this
52 subsection shall be in the form of a class action.

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

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

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

8 (3) Effective January 1, 2003, accept claims for reimbursement from health care
9 providers that are filed electronically. Effective January 1, 2003, all claims for
10 reimbursement filed with health carriers by health care providers that are submitted
11 electronically shall be filed in a form and format specified by the department of insurance.
12 Once such form has been completed in its entirety, then such claim shall be deemed a
13 "clean claim". The department of insurance shall promulgate rules specifying the form
14 and format governing such electronic claims submission consistent with federal
15 administrative simplifications standards adopted pursuant to the Health Insurance
16 Portability and Accountability Act of 1996;

17 (4) Issue within 24 hours, for all claims filed electronically, confirmation of
18 receiving a claim for reimbursement;

19 (5) When processing claims, accept all codes, including modifiers, that are included
20 within the physician's current procedural terminology (CPT) of the American Medical
21 Association, as amended; the Health Care Financing Administration's common procedure
22 coding system (HCPCS), as amended; the International Classification of Diseases 9th
23 Revision Clinical Modification (ICD-9-CM) system, as amended; Diagnosis Related Group
24 (DRG) coding, as amended; and any additional procedure, diagnosis and treatment codes

25 approved by the department of insurance. The department of insurance shall promulgate
26 rules for the implementation of such standard codes and the approval of additional
27 procedure, diagnosis and treatment codes; and

28 (6) During contract negotiations with providers and upon delivery of the final
29 contract, provide a current fee schedule for provider reimbursement for all covered
30 services for which the health care professional is contracted to provide and forward to the
31 provider, at least thirty days in advance of the effective date of such modifications, all
32 modifications to such fee schedule.

33 2. No health carrier shall request a refund or offset against a claim more than
34 twelve months after a carrier has paid a claim except in cases of fraud or misrepresentation
35 by the provider.

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

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

42 5. Effective July 1, 2002, a health carrier shall issue to each enrollee an enrollee
43 card which includes a telephone number for the plan, prescription drug information and
44 a brief description of the enrollee's type of health care plan. Such description shall include,
45 but not be limited to, terms such as preferred provider organization, point of service,
46 health maintenance organization or indemnity plan. Such enrollee card shall be reissued
47 upon any change in the enrollee's benefits or coverage that impacts the information
48 included on the card.

49 6. No rule or portion of a rule promulgated pursuant to the authority of this section
50 shall become effective unless it has been promulgated pursuant to the provisions of chapter
51 536, RSMo.

376.406. 1. All [individual and group health insurance policies providing coverage on
2 an expense incurred basis, individual and group service or indemnity type contracts issued by a
3 nonprofit corporation, and all self-insured group health benefit plans, of any type or description,]
4 **health benefit plans, as defined in section 376.1350**, which provide coverage for a family
5 member of [the insured or subscriber] **an enrollee** shall, as to such family member's coverage,
6 also provide that the health [insurance] benefits applicable for children shall be payable with
7 respect to a newly born child of the [insured or subscriber] **enrollee** from the moment of birth.

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

10 abnormalities.

11 3. If payment of a specific premium or subscription fee is required to provide coverage
12 for a child, the [policy or contract] **health benefit plan** may require that notification of birth of
13 a newly born child and payment of the required premium or fees must be furnished to the [insurer
14 or nonprofit service or indemnity corporation] **health carrier** within thirty-one days after the
15 date of birth in order to have the coverage continue beyond such thirty-one day period. **If an
16 application or other form of enrollment is required in order to continue coverage beyond
17 the thirty-one-day period after the date of birth and the enrollee has notified the health
18 carrier of the birth, either orally or in writing, the health carrier shall, upon notification,
19 provide the enrollee with all forms and instructions necessary to enroll the newly born
20 child and shall allow the enrollee an additional ten days from the date the forms and
21 instructions are provided in which to enroll the newly born child.**

22 4. The requirements of this section shall apply to all [insurance policies and subscriber
23 contracts] **health benefit plans** delivered or issued for delivery in this state [more than one
24 hundred twenty days after August 13, 1974] **on or after August 28, 2001.**

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

29 6. **As used in this section, the terms "health benefit plan", "health carrier" and
30 "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
2 contractual arrangement whereby a health care provider assumes the sole liability inherent
3 in the provision of health care services, thereby relieving an insurer from such liability
4 except that nothing in this section shall be construed to apply to any clause in the contract
5 prohibiting providers from balance billing the enrollee or his or her family for any amount
6 in excess of the amount provided for in the contract between the provider and the carrier.
7 For purposes of this section, "health care provider" or "provider" means a health care
8 professional or facility.**

9 2. **Except to the extent preempted by the Employee Retirement Income Security Act
10 of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section shall apply to any health carrier, as
11 defined in section 376.1350.**

12 3. **Any contract between a health care provider and a health carrier entered into
13 after the effective date of this section shall include a clause that states that each party shall
14 be responsible for any and all claims, liabilities, damages or judgments which may arise
15 as a result of its own negligence or intentional wrongdoing. Each party signatory to the**

16 **contract shall hold harmless and indemnify the other party against any claims, liabilities,**
17 **damages or judgments which may be asserted against, imposed upon or incurred by the**
18 **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
2 of marriage or prior to the expiration of a thirty- six month federal Consolidated Omnibus
3 Budget Reconciliation Act (COBRA) continuation period covering a legally separated or
4 divorced spouse, if such spouse has elected and maintained such COBRA coverage, a legally
5 separated or divorced spouse eligible for continued coverage [under] **pursuant to** section
6 376.892 who seeks such coverage shall give the plan administrator written notice of the legal
7 separation or dissolution. The notice shall include the mailing address of the legally separated
8 or divorced spouse.

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

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

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

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

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

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

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

30 5. If a plan administrator was properly notified pursuant to the provisions of subsection
31 1 or 2 of this section and fails to notify the legally separated, divorced or surviving spouse as
32 required by subsection 3 of this section, such spouse's coverage shall continue in effect, and such
33 spouse's obligation to make any premium payment for continuation coverage [under] **pursuant**

34 to sections 376.891 to 376.894 shall be postponed for the period of time beginning on the date
35 the spouse's coverage would otherwise terminate and ending thirty-one days after the date the
36 plan administrator provides the required notice. Failure or delay by a plan administrator in
37 providing the notice required by this section shall not reduce, eliminate or postpone the plan
38 sponsor's obligation to pay premiums on behalf of such legally separated, divorced or surviving
39 spouse to the plan administrator during such period.

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

**376.895. Any health carrier, as defined in section 376.1350, providing coverage for
2 a child with parents who are legally separated or divorced shall provide upon request
3 coverage information regarding such child to both parents regardless of whether the
4 inquiring parent is the primary policyholder.**

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

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

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

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

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

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

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

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

- 25 (8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under
26 the terms of a health benefit plan;
- 27 (9) "Director", the director of the department of insurance;
- 28 (10) "Discharge planning", the formal process for determining, prior to discharge from
29 a facility, the coordination and management of the care that a patient receives following
30 discharge from a facility;
- 31 (11) "Drug", any substance prescribed by a licensed health care provider acting within
32 the scope of the provider's license and that is intended for use in the diagnosis, mitigation,
33 treatment or prevention of disease. The term includes only those substances that are approved
34 by the FDA for at least one indication;
- 35 (12) "Emergency medical condition", the sudden and, at the time, unexpected onset of
36 a health condition that manifests itself by symptoms of sufficient severity that would lead a
37 prudent lay person, possessing an average knowledge of medicine and health, to believe that
38 immediate medical care is required, which may include, but shall not be limited to:
- 39 (a) Placing the person's health in significant jeopardy;
- 40 (b) Serious impairment to a bodily function;
- 41 (c) Serious dysfunction of any bodily organ or part;
- 42 (d) Inadequately controlled pain; or
- 43 (e) With respect to a pregnant woman who is having contractions:
- 44 a. That there is inadequate time to effect a safe transfer to another hospital before
45 delivery; or
- 46 b. That transfer to another hospital may pose a threat to the health or safety of the woman
47 or unborn child;
- 48 (13) "Emergency service", a health care item or service furnished or required to evaluate
49 and treat an emergency medical condition, which may include, but shall not be limited to, health
50 care services that are provided in a licensed hospital's emergency facility by an appropriate
51 provider;
- 52 (14) "Enrollee", a policyholder, subscriber, covered person or other individual
53 participating in a health benefit plan;
- 54 (15) "FDA", the federal Food and Drug Administration;
- 55 (16) "Facility", an institution providing health care services or a health care setting,
56 including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical
57 or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory
58 and imaging centers, and rehabilitation and other therapeutic health settings;
- 59 (17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding
60 the:

- 61 (a) Availability, delivery or quality of health care services, including a complaint
62 regarding an adverse determination made pursuant to utilization review;
- 63 (b) Claims payment, handling or reimbursement for health care services; or
- 64 (c) Matters pertaining to the contractual relationship between an enrollee and a health
65 carrier;
- 66 (18) "Health benefit plan", a policy, contract, certificate or agreement entered into,
67 offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of
68 the costs of health care services;
- 69 (19) "Health care professional", a physician or other health care practitioner licensed,
70 accredited or certified by the state of Missouri to perform specified health services consistent
71 with state law;
- 72 (20) "Health care provider" or "provider", a health care professional or a facility;
- 73 (21) "Health care service", a service **or prescription medication** for the diagnosis,
74 prevention, treatment, cure or relief of a health condition, illness, injury or disease;
- 75 (22) "Health carrier", an entity subject to the insurance laws and regulations of this state
76 that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of
77 the costs of health care services, including a sickness and accident insurance company, a health
78 maintenance organization, a nonprofit hospital and health service corporation, or any other entity
79 providing a plan of health insurance, health benefits or health services;
- 80 (23) "Health indemnity plan", a health benefit plan that is not a managed care plan;
- 81 (24) "Managed care plan", a health benefit plan that either requires an enrollee to use,
82 or creates incentives, including financial incentives, for an enrollee to use, health care providers
83 managed, owned, under contract with or employed by the health carrier;
- 84 (25) "Participating provider", a provider who, under a contract with the health carrier or
85 with its contractor or subcontractor, has agreed to provide health care services to enrollees with
86 an expectation of receiving payment, other than coinsurance, co-payments or deductibles,
87 directly or indirectly from the health carrier;
- 88 (26) "Peer-reviewed medical literature", a published scientific study in a journal or other
89 publication in which original manuscripts have been published only after having been critically
90 reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and
91 that has been determined by the International Committee of Medical Journal Editors to have met
92 the uniform requirements for manuscripts submitted to biomedical journals or is published in a
93 journal specified by the United States Department of Health and Human Services pursuant to
94 section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable peer-reviewed
95 medical literature. Peer-reviewed medical literature shall not include publications or
96 supplements to publications that are sponsored to a significant extent by a pharmaceutical

97 manufacturing company or health carrier;

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

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

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

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

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

112 (32) "Standard reference compendia":

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

114 (b) The United States Pharmacopoeia-Drug Information;

115 (33) "Utilization review", a set of formal techniques designed to monitor the use of, or
116 evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services,
117 procedures, or settings. Techniques may include ambulatory review, prospective review, second
118 opinion, certification, concurrent review, case management, discharge planning or retrospective
119 review. Utilization review shall not include elective requests for clarification of coverage;

120 (34) "Utilization review organization", a utilization review agent as defined in section
121 374.500, RSMo.

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

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

10 3. A health carrier shall issue utilization review decisions in a timely manner pursuant
11 to the requirements of sections 376.1363, 376.1365 and 376.1367. A health carrier shall obtain

12 all information required to make a utilization review decision, including pertinent clinical
13 information. A health carrier shall have a process to ensure that utilization reviewers apply
14 clinical review criteria consistently.

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

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

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

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

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

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

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

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

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

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

42 11. (1) This subsection shall apply to:

43 (a) Any health benefit plan that is issued, amended, delivered or renewed on or after
44 January 1, 1998, and provides coverage for drugs; or

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

47 (2) A health benefit plan that provides coverage for drugs shall provide coverage for any

48 drug prescribed to treat an indication so long as the drug has been approved by the FDA for at
49 least one indication, if the drug is recognized for treatment of the covered indication in one of
50 the standard reference compendia or in substantially accepted peer-reviewed medical literature
51 and deemed medically appropriate.

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

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

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

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

63 (7) **Every health carrier shall notify the dispensing pharmacy, prescribing**
64 **physician and enrollee when a nonformulary drug is authorized with conditions, such as**
65 **an authorization for a limited period of time.**

66 12. A carrier shall issue a confirmation number to an enrollee when the health carrier,
67 acting through a participating provider or other authorized representative, [authorizes] **certifies**
68 the provision of health care services.

69 13. If an authorized representative of a health carrier [authorizes] **certifies** the provision
70 of health care services, the health carrier shall not subsequently retract its [authorization]
71 **certification** after the health care services have been provided, or reduce payment for an item
72 or service furnished in reliance on [approval] **such certification**, unless:

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

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

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

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

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

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

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

7 (3) When an enrollee receives an emergency service that requires immediate post
8 evaluation or post stabilization services, a health carrier shall provide [an authorization] a
9 **certification** decision within [sixty] **forty-five** minutes of receiving a request; if the
10 [authorization] **certification** decision is not made within [thirty] **forty-five** minutes, such
11 services shall be deemed approved.

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

**7 2. The standardized form developed by the task force as established in section
8 376.1408 shall contain the following:**

- 9 (1) The name of the insured;
10 (2) The insured's identification number;
11 (3) The date of service;
12 (4) Amount of charge;
13 (5) Explanation for any denial;
14 (6) The amount paid and any balance due;
15 (7) The procedure code;
16 (8) The patient's full name; and
17 (9) The phone number and name of whom to contact for questions on explanation
18 of benefits.

19 **3. All health insurance carriers shall use the standard explanation of benefits form
20 after January 1, 2004.**

21 **4. Every health carrier shall after January 1, 2004, make formulary information
22 available to participating pharmacies through the Internet or other electronic means. The
23 department of insurance shall develop rules to implement the requirements of this
24 subsection and to protect the proprietary rights of the health carrier.**

25 **5. The provisions of this section shall be preempted if a federal regulating entity
26 develops a standardized form for the explanation of benefits which is applicable to all
27 health carriers as defined in section 376.1350.**

**376.1406. 1. Every health care provider and health carrier that conducts business
2 in this state shall use a standardized form for referrals. The standardized referral form**

3 shall be used in lieu of any specific referral form developed by a health carrier for the
4 referral process. As used in this section, the terms "health care provider" and "health
5 carrier" shall have the meaning given to them in section 376.1350.

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

8 (1) The name of the insured;

9 (2) Place of employment;

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

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

12 (5) The type of referral;

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

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

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

18 (9) The health carrier's authorization number.

19 3. All health care providers and health carriers shall use the standardized referral
20 form after January 1, 2004.

21 4. The provisions of this section shall be preempted if a federal regulating entity
22 develops a standardized form for referrals which is applicable to all health carriers as
23 defined in section 376.1350.

376.1408. The department of insurance shall, for any forms required by sections
2 376.1405 and 376.1406, adopt any standardized forms adopted by the Federal Health Care
3 Financing Administration for such purpose.

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

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

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

12 (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 consistent with the carrier's contract with the Health Care Financing Administration for long-term care services.

[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

- 15 (8) The health carrier's authorization number.
16 3. All health care providers and health carriers shall use the standardized
17 referral information after January 1, 2002.]