

FIRST REGULAR SESSION

HOUSE BILL NO. 225

92ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE LUETKEMEYER.

Read 1st time January 21, 2003, and copies ordered printed.

STEPHEN S. DAVIS, Chief Clerk

1008L.011

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Section A. Section 354.603, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 354.603, to read as follows: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

19 provision, the director shall give due consideration to the relative availability of health care
20 providers in the service area under, especially rural areas, consideration.

21 (3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and
22 legal authority of its providers to furnish all contracted benefits to enrollees. The provisions of
23 this subdivision shall not be construed to require any health care provider to submit copies of
24 such health care provider's income tax returns to a health carrier. A health carrier may require
25 a health care provider to obtain audited financial statements if such health care provider received
26 ten percent or more of the total medical expenditures made by the health carrier.

27 (4) A health carrier shall make its entire network available to all enrollees unless a
28 contract holder has agreed in writing to a different or reduced network.

29 2. A health carrier shall file with the director, in a manner and form defined by rule of
30 the department of insurance, an access plan meeting the requirements of sections 354.600 to
31 354.636 for each of the managed care plans that the health carrier offers in this state. The health
32 carrier may request the director to deem sections of the access plan as proprietary or competitive
33 information that shall not be made public. For the purposes of this section, information is
34 proprietary or competitive if revealing the information will cause the health carrier's competitors
35 to obtain valuable business information. The health carrier shall provide such plans, absent any
36 information deemed by the director to be proprietary, to any interested party upon request. The
37 health carrier shall prepare an access plan prior to offering a new managed care plan, and shall
38 update an existing access plan whenever it makes any change as defined by the director to an
39 existing managed care plan. The director shall approve or disapprove the access plan, or any
40 subsequent alterations to the access plan, within sixty days of filing. The access plan shall
41 describe or contain at a minimum the following:

42 (1) The health carrier's network;

43 (2) The health carrier's procedures for making referrals within and outside its network;

44 (3) The health carrier's process for monitoring and assuring on an ongoing basis the
45 sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

46 (4) The health carrier's methods for assessing the health care needs of enrollees and their
47 satisfaction with services;

48 (5) The health carrier's method of informing enrollees of the plan's services and features,
49 including but not limited to, the plan's grievance procedures, its process for choosing and
50 changing providers, and its procedures for providing and approving emergency and specialty
51 care;

52 (6) The health carrier's system for ensuring the coordination and continuity of care for
53 enrollees referred to specialty physicians, for enrollees using ancillary services, including social
54 services and other community resources, and for ensuring appropriate discharge planning;

55 (7) The health carrier's process for enabling enrollees to change primary care
56 professionals;

57 (8) The health carrier's proposed plan for providing continuity of care in the event of
58 contract termination between the health carrier and any of its participating providers, in the event
59 of a reduction in service area or in the event of the health carrier's insolvency or other inability
60 to continue operations. The description shall explain how enrollees shall be notified of the
61 contract termination, reduction in service area or the health carrier's insolvency or other
62 modification or cessation of operations, and transferred to other health care professionals in a
63 timely manner; and

64 (9) Any other information required by the director to determine compliance with the
65 provisions of sections 354.600 to 354.636.

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

69 **(1) The managed care plan is a Medicare + Choice coordinated care plan offered**
70 **by the health carrier pursuant to a contract with the federal Centers for Medicare and**
71 **Medicaid Services;**

72 **(2) The managed care plan is being offered by a health carrier that has been**
73 **accredited by the National Committee for Quality Assurance at a level of "accredited" or**
74 **better, and such accreditation is in effect at the time the access plan is filed; or**

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