FIRST REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED]

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 121

92ND GENERAL ASSEMBLY

0311S.11T 2003

AN ACT

To repeal sections 354.085, 354.405, 354.603, and 430.225, RSMo, and to enact in lieu thereof six new sections relating to managed care chiropractic services.

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

Section A. Sections 354.085, 354.405, 354.603, and 430.225, RSMo, are repealed and six new sections enacted in lieu thereof, to be known as sections 354.085, 354.405, 354.603, 376.1230, 376.1231, and 430.225, to read as follows: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 shall not disapprove any deemed policy form 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 policy form is contrary to state law, the director shall notify the health services corporation of the specific provision that is contrary to state law, and any specific statute to which the provision is contrary to, and request that the health services corporation file, within thirty days of receipt of the request, an amendment form that modifies the provision to conform to state law. Upon approval of the amendment form by the director, the health services corporation 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. Such amendment shall have the force and effect as if the amendment was in the original filing or policy. 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, **citing specific reasons for noncompliance,** 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 shall 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 state law, the director shall notify the health maintenance organization of the specific provision that is contrary to state law, and any 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 state law. 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. Such amendment shall have the force and effect as if the amendment was in the original filing or policy.**

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;

(3) The managed care plan's network has been accredited by the joint commission on the accreditation of health organizations for network adequacy, 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; or

(4) The managed care plan is being offered by a health carrier that has been accredited by the utilization review accreditation commission at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed.

376.1230. 1. Every policy issued by a health carrier, as defined in section 376.1350, shall provide coverage for chiropractic care delivered by a licensed chiropractor acting within the scope of his or her practice as defined in chapter 331, RSMo. The coverage shall include initial diagnosis and clinically appropriate and medically necessary services and supplies required to treat the diagnosed disorder, subject to the terms and conditions of the policy. The coverage may be limited to chiropractors within the health carrier's network, and nothing in this section shall be construed to require a health carrier to contract with a chiropractor not in the carrier's network nor shall a carrier be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval has been obtained from the carrier by the enrollee. An enrollee may access chiropractic care within the network for a total of twenty-six chiropractic physician office visits per policy period, but may be required to provide the health carrier with notice prior to any additional visit as a condition of coverage. A health carrier may require prior authorization or notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of twenty-six in any policy period. The certificate of coverage for any health benefit plan issued by a health carrier shall clearly state the availability of chiropractic coverage under the policy and any limitations, conditions, and exclusions.

2. The provisions of sections 376.1230 and 376.1231 shall not apply to any health plan or contract that is individually underwritten.

3. The provisions of sections 376.1230 and 376.1231 shall not apply to benefits provided under the Medicaid program.

4. The provisions of sections 376.1230 and 376.1231 shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months' or less duration, or any other similar supplemental policy.

376.1231. A health benefit plan shall provide coverage for treatment of a chiropractic care condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a chiropractic care condition than for access to treatment for another physical health condition.

430.225. 1. As used in sections 430.225 to 430.250, the following terms shall mean:

(1) "Claim", a claim of a patient for:

(a) Damages from a tort-feasor; or

(b) Benefits from an insurance carrier;

(2) "Clinic", a group practice of health practitioners or a sole practice of a health practitioner who has incorporated his or her practice;

(3) "Health practitioner", a chiropractor licensed pursuant to chapter 331, RSMo, a podiatrist licensed pursuant to chapter 330, RSMo, a dentist licensed pursuant to chapter 332, RSMo, a physician or surgeon licensed pursuant to chapter 334, RSMo, or an optometrist licensed pursuant to chapter 336, RSMo, while acting within the scope of their practice;

(4) "Insurance carrier", any person, firm, corporation, association or aggregation of persons conducting an insurance business pursuant to chapter 375, 376, 377, 378, 379, 380, 381, or 383, RSMo;

(5) "Other institution", a legal entity existing pursuant to the laws of this state which delivers treatment, care or maintenance to patients who are sick or injured;

(6) "Patient", any person to whom a health practitioner, hospital, clinic or other institution delivers treatment, care or maintenance for sickness or injury caused by a tort-feasor from whom such person seeks damages or any insurance carrier which has insured such tort-feasor.

2. Clinics, health practitioners and other institutions, as defined in this section shall have the same rights granted to hospitals in sections 430.230 to 430.250.

3. If the liens of such health practitioners, hospitals, clinics or other institutions exceed fifty percent of the amount due the patient, every health care practitioner, hospital, clinic or other institution giving notice of its lien, as aforesaid, shall share in up to fifty percent of the net proceeds due the patient, in the proportion that each claim bears to the total amount of all other liens of health care practitioners, hospitals, clinics or other institutions. "Net proceeds", as used in this section, means the amount remaining after the payment of contractual attorney fees, if any, and other expenses of recovery.

4. In administering the lien of the health care provider, the insurance carrier may pay the amount due secured by the lien of the health care provider directly, if the claimant authorizes it and does not challenge the amount of the customary charges or that the treatment provided was for injuries cause by the tort-feasor.

5. Any health care provider electing to receive benefits hereunder releases the claimant from further liability on the cost of the services and treatment provided to that point in time.

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