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SENATE SUBSTITUTE

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HOUSE BILL NO. 121

AN ACT

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

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

1 Section A. Sections 354.085, 354.405, and 354.603, RSMo,
2 are repealed and five new sections enacted in lieu thereof, to be
3 known as sections 354.085, 354.405, 354.603, 376.1230, and
4 376.1231, to read as follows:
5 354.085. No corporation subject to the provisions of
6 sections 354.010 to 354.380 shall deliver or issue for delivery
7 in this state a form of membership contract, or any endorsement
8 or rider thereto, until a copy of the form shall have been
9 approved by the director. The director shall not approve any
10 policy forms which are not in compliance with the provisions of
11 sections 354.010 to 354.380 of this state, or which contain any
12 provision which is deceptive, ambiguous or misleading, or which

1 do not contain such words, phraseology, conditions and provisions
2 which are specific, certain and reasonably adequate to meet
3 needed requirements for the protection of those insured. If a
4 policy form is disapproved, the reasons therefor shall be stated
5 in writing; a hearing shall be granted upon such disapproval, if
6 so requested; provided, however, that such hearing shall be held
7 no sooner than fifteen days following the request. The failure
8 of the director of insurance to take action approving or
9 disapproving a submitted policy form within [thirty] forty-five
10 days from the date of filing shall be deemed an approval thereof
11 [until such time as the director of insurance shall notify the
12 submitting company, in writing, of his disapproval]. The
13 director shall not disapprove any deemed policy form for a period
14 of twelve months thereafter. If at any time during that twelve-
15 month period the director determines that any provision of the
16 deemed policy form is contrary to state law, the director shall
17 notify the health services corporation of the specific provision
18 that is contrary to state law, and any specific statute to which
19 the provision is contrary to, and request that the health
20 services corporation file, within thirty days of receipt of the
21 request, an amendment form that modifies the provision to conform
22 to state law. Upon approval of the amendment form by the
23 director, the health services corporation shall issue a copy of
24 the amendment to each individual and entity to which the deemed
25 policy form was previously issued and shall attach a copy of the
26 amendment to the deemed policy form when it is subsequently
27 issued. Such amendment shall have the force and effect as if the
28 amendment was in the original filing or policy. The director of

1 insurance shall have authority to make such reasonable rules and
2 regulations concerning the filing and submission of such policy
3 forms as are necessary, proper or advisable.
4 354.405. 1. Notwithstanding any law of this state to the
5 contrary, any person may apply to the director for a certificate
6 of authority to establish and operate a health maintenance
7 organization in compliance with this act. No person shall
8 establish or operate a health maintenance organization in this
9 state without obtaining a certificate of authority pursuant to
10 sections 354.400 to 354.636. A foreign corporation may qualify
11 pursuant to sections 354.400 to 354.636, subject to its
12 registration to do business in this state as a foreign
13 corporation pursuant to chapter 351, RSMo, and compliance with
14 the provisions of sections 354.400 to 354.636.
15 2. Every health maintenance organization doing business in
16 this state on September 28, 1983, shall submit an application for
17 a certificate of authority pursuant to subsection 3 of this
18 section within one hundred twenty days of September 28, 1983.
19 Each such applicant may continue to operate until the director
20 acts upon the application. In the event that an application is
21 not submitted or is denied pursuant to section 354.410, the
22 applicant shall henceforth be treated as a health maintenance
23 organization whose certificate of authority has been revoked.
24 Any health maintenance organization licensed by the department of
25 insurance prior to September 28, 1983, and complying with the
26 paid-in capital or guarantee fund requirements of section 354.410
27 shall be issued a certificate of authority upon filing an amended
28 certificate of authority and an amended articles of incorporation

1 that conform with sections 354.400 to 354.636. When the annual
2 statement of a health maintenance organization subject to the
3 provisions of sections 354.400 to 354.636 is filed and all fees
4 due from the health maintenance organization are tendered, the
5 health maintenance organization's certificate of authority to do
6 business in this state shall automatically be extended pending
7 formal renewal by the director, or until such time as the
8 director should refuse to renew the certificate.
9 3. Each application for a certificate of authority shall be
10 verified by an officer or authorized representative of the
11 applicant, shall be in a form prescribed by the director, and
12 shall set forth or be accompanied by the following:
13 (1) A copy of the organizational documents of the applicant
14 such as the articles of incorporation, articles of association,
15 partnership agreement, trust agreement, or other applicable
16 documents, and all amendments thereto;
17 (2) A copy of the bylaws, rules and regulations, or similar
18 document, if any, regulating the conduct of the internal affairs
19 of the applicant;
20 (3) A list of the names, addresses, and official positions
21 of the persons who are to be responsible for the conduct of the
22 affairs of the applicant, including all members of the board of
23 directors, board of trustees, executive committee, or other
24 governing board or committee, the principal officers if the
25 applicant is a corporation, and the partners or members if the
26 applicant is a partnership or association;
27 (4) A copy of any contract made or to be made between any
28 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,

1 an amendment form that modifies the provision to conform to the
2 state law. Upon approval of the amendment form by the director,
3 the health maintenance organization shall issue a copy of the
4 amendment to each individual and entity to which the deemed
5 filing was previously issued and shall attach a copy of the
6 amendment to the deemed filing when it is subsequently issued.
7 Such amendment shall have the force and effect as if the
8 amendment was in the original filing or policy.
9 5. A health maintenance organization shall file all
10 contracts of reinsurance. Any agreement between the organization
11 and an insurer shall be subject to the laws of this state
12 regarding reinsurance. All reinsurance agreements and any
13 modifications thereto shall be filed and approved.
14 6. When the director deems it appropriate, the director may
15 exempt any item from the filing requirements of this section.
16 354.603. 1. A health carrier shall maintain a network that
17 is sufficient in number and types of providers to assure that all
18 services to enrollees shall be accessible without unreasonable
19 delay. In the case of emergency services, enrollees shall have
20 access twenty-four hours per day, seven days per week. The
21 health carrier's medical director shall be responsible for the
22 sufficiency and supervision of the health carrier's network.
23 Sufficiency shall be determined by the director in accordance
24 with the requirements of this section and by reference to any
25 reasonable criteria, including but not limited to,
26 provider-enrollee ratios by specialty, primary care
27 provider-enrollee ratios, geographic accessibility, reasonable
28 distance accessibility criteria for pharmacy and other services,

1 waiting times for appointments with participating providers,
2 hours of operation, and the volume of technological and specialty
3 services available to serve the needs of enrollees requiring
4 technologically advanced or specialty care.
5 (1) In any case where the health carrier has an
6 insufficient number or type of participating providers to provide
7 a covered benefit, the health carrier shall ensure that the
8 enrollee obtains the covered benefit at no greater cost than if
9 the benefit was obtained from a participating provider, or shall
10 make other arrangements acceptable to the director.
11 (2) The health carrier shall establish and maintain
12 adequate arrangements to ensure reasonable proximity of
13 participating providers, including local pharmacists, to the
14 business or personal residence of enrollees. In determining
15 whether a health carrier has complied with this provision, the
16 director shall give due consideration to the relative
17 availability of health care providers in the service area under,
18 especially rural areas, consideration.
19 (3) A health carrier shall monitor, on an ongoing basis,
20 the ability, clinical capacity, and legal authority of its
21 providers to furnish all contracted benefits to enrollees. The
22 provisions of this subdivision shall not be construed to require
23 any health care provider to submit copies of such health care
24 provider's income tax returns to a health carrier. A health
25 carrier may require a health care provider to obtain audited
26 financial statements if such health care provider received ten
27 percent or more of the total medical expenditures made by the
28 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

1 meet the health care needs of enrollees of the managed care plan;
2 (4) The health carrier's methods for assessing the health
3 care needs of enrollees and their satisfaction with services;
4 (5) The health carrier's method of informing enrollees of
5 the plan's services and features, including but not limited to,
6 the plan's grievance procedures, its process for choosing and
7 changing providers, and its procedures for providing and
8 approving emergency and specialty care;
9 (6) The health carrier's system for ensuring the
10 coordination and continuity of care for enrollees referred to
11 specialty physicians, for enrollees using ancillary services,
12 including social services and other community resources, and for
13 ensuring appropriate discharge planning;
14 (7) The health carrier's process for enabling enrollees to
15 change primary care professionals;
16 (8) The health carrier's proposed plan for providing
17 continuity of care in the event of contract termination between
18 the health carrier and any of its participating providers, in the
19 event of a reduction in service area or in the event of the
20 health carrier's insolvency or other inability to continue
21 operations. The description shall explain how enrollees shall be
22 notified of the contract termination, reduction in service area
23 or the health carrier's insolvency or other modification or
24 cessation of operations, and transferred to other health care
25 professionals in a timely manner; and
26 (9) Any other information required by the director to
27 determine compliance with the provisions of sections 354.600 to
28 354.636.

1 3. In reviewing an access plan filed pursuant to subsection
2 2 of this section, the director shall deem a managed care plan's
3 network to be adequate if it meets one or more of the following
4 criteria:
5 (1) The managed care plan is a Medicare + Choice
6 coordinated care plan offered by the health carrier pursuant to a
7 contract with the federal Centers for Medicare and Medicaid
8 Services;
9 (2) The managed care plan is being offered by a health
10 carrier that has been accredited by the National Committee for
11 Quality Assurance at a level of "accredited" or better, and such
12 accreditation is in effect at the time the access plan is filed;
13 (3) The managed care plan's network has been accredited by
14 the joint commission on the accreditation of health organizations
15 for network adequacy, and such accreditation is in effect at the
16 time the access plan is filed. If the accreditation applies to
17 only a portion of the managed care plan's network, only the
18 accredited portion will be deemed adequate; or
19 (4) The managed care plan is being offered by a health
20 carrier that has been accredited by the utilization review
21 accreditation commission at a level of "accredited" or better,
22 and such accreditation is in effect at the time the access plan
23 is filed.
24 376.1230. 1. Every policy issued by a health carrier, as
25 defined in section 376.1350, shall provide coverage for
26 chiropractic care delivered by a licensed chiropractor acting
27 within the scope of his or her practice as defined in chapter
28 331, RSMo. The coverage shall include initial diagnosis and

1 clinically appropriate and medically necessary services and
2 supplies required to treat the diagnosed disorder, subject to the
3 terms and conditions of the policy. The coverage may be limited
4 to chiropractors within the health carrier's network, and nothing
5 in this section shall be construed to require a health carrier to
6 contract with a chiropractor not in the carrier's network nor
7 shall a carrier be required to reimburse for services rendered by
8 a nonnetwork chiropractor unless prior approval has been obtained
9 from the carrier by the enrollee. An enrollee may access
10 chiropractic care within the network for a total of twenty-six
11 chiropractic physician office visits per policy period, but may
12 be required to provide the health carrier with notice prior to
13 any additional visit as a condition of coverage. A health
14 carrier may require prior authorization or notification before
15 any follow-up diagnostic tests are ordered by a chiropractor or
16 for any office visits for treatment in excess of twenty-six in
17 any policy period. The certificate of coverage for any health
18 benefit plan issued by a health carrier shall clearly state the
19 availability of chiropractic coverage under the policy and any
20 limitations, conditions, and exclusions.
21 2. The provisions of sections 376.1230 and 376.1231 shall
22 not apply to any health plan or contract that is individually
23 underwritten.
24 3. The provisions of sections 376.1230 and 376.1231 shall
25 not apply to benefits provided under the Medicaid program.
26 4. The provisions of sections 376.1230 and 376.1231 shall
27 not apply to a supplemental insurance policy, including a life
28 care contract, accident-only policy, specified disease policy,

1 hospital policy providing a fixed daily benefit only, Medicare
2 supplement policy, long-term care policy, short-term major
3 medical policy of six months' or less duration, or any other
4 similar supplemental policy.
5 376.1231. A health benefit plan shall provide coverage for
6 treatment of a chiropractic care condition and shall not
7 establish any rate, term, or condition that places a greater
8 financial burden on an insured for access to treatment for a
9 chiropractic care condition than for access to treatment for
10 another physical health condition.