SS SCS HS HCS HB 121 -- CHIROPRACTIC CARE; MANAGED CARE; LIENS OF HOSPITALS AND HEALTH CARE PROFESSIONALS

This bill contains provisions pertaining to insurance coverage for chiropractic care, managed care entities, and liens filed by hospitals and health care professionals.

INSURANCE COVERAGE FOR CHIROPRACTIC CARE

The bill requires health insurers to provide coverage for chiropractic care delivered by a licensed chiropractor acting within the scope of Chapter 331, RSMo.

The coverage will include initial diagnosis and clinically appropriate and medically necessary services and supplies required to treat a diagnosed disorder, subject to conditions of the policy. The coverage may be limited to chiropractors within the health carrier’s network. Health carriers are not required to contract with a chiropractor outside the health carrier’s network nor are carriers required to reimburse for services provided by a non-network chiropractor, unless prior approval has been obtained from the health carrier by the enrollee.

Enrollees may access chiropractic care within the health carrier’s network for a total of 26 chiropractic office visits per policy period and may be required to provide the health carrier with notice prior to any additional visits as a condition of coverage. In addition, health carriers may require prior authorization or notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office visits for treatments in excess of 26 office visits in a policy period.

Certificates of coverage for any health benefit plan are required to state the availability of chiropractic coverage under the policy and any exclusions, limitations, or conditions of coverage. The insurance coverage contained in the bill excludes benefits provided under the Medicaid program and other specified insurance policies.

Health carriers are prohibited from establishing rates, terms, and conditions of coverage for enrollees which cause a greater financial burden than for enrollees who access treatment for other physical conditions.

MANAGED CARE ENTITIES

The bill revises certain provisions pertaining to health services corporations, health maintenance organizations, and managed care plan networks.

Pertaining to health services corporations, the bill:

(1) Extends the approval or disapproval period from 30 days to 45 days during which the Director of the Department of Insurance is required to review and approve or disapprove submitted policy forms by a health services corporation. A non-determination on the submitted policy forms by the director during this period constitutes approval of the forms;

(2) Prohibits the director from disapproving a filed policy form for a period of one year. During the one-year period, if the director determines that any provision of the policy form violates state law, the director is required to notify the health services corporation of the specific provision of the policy form which is contrary to state law and the state law used to determine the illegality of the policy form and request that the health services corporation file an amendment with the department within 30 days; and

(3) Requires that the amendment approved by the director will have the effect of the original filing or policy filed with the department.

Pertaining to health maintenance organizations, the bill:

(1) Extends the approval or disapproval period from 30 days to 45 days during which the Director of the Department of Insurance is required to review and approve or disapprove modifications of various documents, including articles of incorporation, financial statements, policies, and marketing plans submitted by health maintenance organizations. A non-determination on the submitted documents by the director during this period constitutes an approval of the modified documents;

(2) Prohibits the director from disapproving a filing of specific information by health maintenance organizations deemed approved for a period of one year. During the one-year period, if the director determines that any provision of the required filing violates state law, the director is required to notify the health maintenance organization of the specific provision of the required filing which is contrary to state law and the state law used to determine the illegality of the required filing and request that the health maintenance organization file an amendment with the department within 30 days; and

(3) Requires the health maintenance organization to issue a copy of the amendment approved by the director to individuals and entities which received the previous filing. The amendment will have the effect of the original filing or policy filed with the department.

Pertaining to managed health plan networks, the bill requires the Director of the Department of Insurance to deem a managed care plan network adequate based on certain criteria which are detailed.

LIENS OF HOSPITALS AND HEALTH CARE PROFESSIONALS

The bill revises Section 430.225, the definition section pertaining to liens of hospitals and certain health care providers.