SECOND REGULAR SESSION

SENATE BILL NO. 972

95TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR DEMPSEY.

Read 1st time February 18, 2010, and ordered printed.

TERRY L. SPIELER, Secretary.

5146S.02I

AN ACT

To repeal sections 354.442 and 376.1450, RSMo, and to enact in lieu thereof two new sections relating to documents and materials for health insurance enrollees.

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

Section A. Sections 354.442 and 376.1450, RSMo, are repealed and two new sections enacted in lieu thereof, to be known as sections 354.442 and 376.1450, to read as follows:

354.442. 1. Each enrollee, and upon request each prospective enrollee prior to enrollment, shall be supplied with written disclosure information. In the event of any inconsistency between any separate written disclosure statement and the enrollee contract or evidence of coverage, the terms of the enrollee contract or evidence of coverage shall be controlling. The information to be disclosed in writing shall include at a minimum the following:

(1) A description of coverage provisions, health care benefits, benefit maximums, including benefit limitations;

(2) A description of any exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(3) A description of all prior authorization or other requirements for treatments and services;

(4) A description of utilization review policies and procedures used by the health maintenance organization, including:

(a) The circumstances under which utilization review shall be undertaken;

(b) The toll-free telephone number of the utilization review agent;

(c) The time frames under which utilization review decisions shall be made for prospective, retrospective and concurrent decisions;

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

(d) The right to reconsideration;

(e) The right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(f) The right to designate a representative;

(g) A notice that all denials of claims shall be made by qualified clinical personnel and that all notices of denial shall include information about the basis of the decision; and

(h) Further appeal rights, if any;

(5) An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charge, annual limits on an enrollee's financial responsibility, caps on payments for covered services and financial responsibility for noncovered health care procedures, treatments or services provided within the health maintenance organization;

(6) An explanation of an enrollee's financial responsibility for payment when services are provided by a health care provider who is not part of the health maintenance organization's network or by any provider without required authorization, or when a procedure, treatment or service is not a covered health care benefit;

(7) A description of the grievance procedures to be used to resolve disputes between a health maintenance organization and an enrollee, including:

(a) The right to file a grievance regarding any dispute between an enrollee and a health maintenance organization;

(b) The right to file a grievance when the dispute is about referrals or covered benefits;

(c) The toll-free telephone number which enrollees may use to file a grievance;

(d) The department of insurance, financial institutions and professional registration's toll-free consumer complaint hot line number;

(e) The time frames and circumstances for expedited and standard grievances;

(f) The right to appeal a grievance determination and the procedures for filing such an appeal;

(g) The time frames and circumstances for expedited and standard appeals;

(h) The right to designate a representative;

(i) A notice that all disputes involving clinical decisions shall be made by

qualified clinical personnel; and

(j) All notices of determination shall include information about the basis of the decision and further appeal rights, if any;

(8) A description of a procedure for providing care and coverage twenty-four hours a day, seven days a week, for emergency services. Such description shall include the definition of emergency services and emergency medical condition, notice that emergency services are not subject to prior approval, and shall describe the enrollee's financial and other responsibilities regarding obtaining such services, including when such services are received outside the health maintenance organization's service area;

(9) A description of procedures for enrollees to select and access the health maintenance organization's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(10) A description of the procedures for changing primary and specialty care providers within the health maintenance organization;

(11) Notice that an enrollee may obtain a referral for covered services to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee may obtain such referral;

(12) A description of the mechanisms by which enrollees may participate in the development of the policies of the health maintenance organization;

(13) Notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization;

(14) **[**A listing**]** **Listings** by specialty, which may be in **[**a**]** separate **[**document that is**]** **documents that are** updated annually, of the names, addresses and telephone numbers of all participating providers, including facilities, and in addition in the case of physicians, board certification; and

(15) The director of the department of insurance, financial institutions and professional registration shall develop a standard credentialing form which shall be used by all health carriers when credentialing health care professionals in a managed care plan. If the health carrier demonstrates a need for additional information, the director of the department of insurance, financial institutions and professional registration may approve a supplement to the standard credentialing form. All forms and supplements shall meet all requirements as

defined by the National Committee of Quality Assurance.

2. Each health maintenance organization shall, upon request of an enrollee or prospective enrollee, provide the following:

(1) A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the health maintenance organization;

(2) A copy of the most recent annual certified financial statement of the health maintenance organization, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(3) A copy of the most recent individual, direct pay enrollee contracts;

(4) Information relating to consumer complaints compiled annually by the department of insurance, financial institutions and professional registration;

(5) The procedures for protecting the confidentiality of medical records and other enrollee information;

(6) An opportunity to inspect drug formularies used by such health maintenance organization and any financial interest in a pharmacy provider utilized by such organization. The health maintenance organization shall also disclose the process by which an enrollee or his representative may seek to have an excluded drug covered as a benefit;

(7) A written description of the organizational arrangements and ongoing procedures of the health maintenance organization's quality assurance program;

(8) A description of the procedures followed by the health maintenance organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(9) Individual health practitioner affiliations with participating hospitals, if any;

(10) Upon written request, written clinical review criteria relating to conditions or diseases and, where appropriate, other clinical information which the organization may consider in its utilization review. The health maintenance organization may include with the information a description of how such information will be used in the utilization review process;

(11) The written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization;

(12) A description of the procedures followed by the health maintenance organization in making decisions about which drugs to include in the health

maintenance organization's drug formulary.

3. Nothing in this section shall prevent a health maintenance organization from changing or updating the materials that are made available to enrollees.

4. The information to be provided under subsections 1 and 2 of this section may be provided online unless a paper copy is requested by the enrollee. A request by the enrollee may include written, oral or electronic means. Such requested paper copy shall be provided to the enrollee within fifteen business days.

376.1450. An enrollee, as defined in section 376.1350, may **[**waive his or her right to**]** receive documents and materials from a managed care entity in printed **or electronic** form so long as such documents and materials are readily accessible **[**electronically through the entity's Internet site. An enrollee may revoke such waiver at any time by notifying the managed care entity by phone or in writing or annually. Any enrollee who does not execute such a waiver and prospective enrollees shall have documents and materials from the managed care entity provided**]** in printed form **upon request. A request by the enrollee may include written, oral, or electronic means. Such requested printed form shall be provided to the enrollee within fifteen business days**. For purposes of this section, "managed care entity" includes, but is not limited to, a health maintenance organization, preferred provider organization, point of service organization and any other managed health care delivery entity of any type or description.

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