MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Representative Martinson

To: Insurance; Appropriations

HOUSE BILL NO. 1279

AN ACT TO AMEND SECTION 81-41-409, MISSISSIPPI CODE OF 1972, TO REQUIRE PARTICIPATING PROVIDERS IN ANY MANAGED CARE PLAN, BEFORE PROVIDING ANY PATIENT ENROLLED IN THE PLAN WITH ANY MEDICAL SERVICE THAT REQUIRES PRECERTIFICATION TO RECEIVE REIMBURSEMENT, TO VERIFY THAT THE PATIENT HAS OBTAINED THE REQUIRED PRECERTIFICATION FOR THAT SERVICE OR, IF NOT DONE BY THE PATIENT, TO OBTAIN THE REQUIRED PRECERTIFICATION FOR THE PATIENT; TO AMEND SECTIONS 25-15-9 AND 25-15-255, MISSISSIPPI CODE OF 1972, TO REQUIRE THE STATE EMPLOYEES HEALTH INSURANCE PLAN AND THE PUBLIC SCHOOL EMPLOYEES HEALTH INSURANCE PLAN TO REQUIRE PROVIDERS PARTICIPATING IN THE PLAN OR IN ANY NETWORK ESTABLISHED UNDER THE PLAN, BEFORE PROVIDING ANY PATIENT ENROLLED IN THE PLAN OR NETWORK WITH ANY MEDICAL SERVICE THAT REQUIRES PRECERTIFICATION TO RECEIVE REIMBURSEMENT, TO VERIFY THAT THE PATIENT HAS OBTAINED THE REQUIRED PRECERTIFICATION FOR THAT SERVICE OR, IF NOT DONE BY THE PATIENT, TO OBTAIN THE REQUIRED PRECERTIFICATION FOR THE PATIENT; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. Section 83-41-409, Mississippi Code of 1972, is amended as follows:

83-41-409. In order to be certified and recertified under this article, a managed care plan shall:

(a) Provide enrollees or other applicants with written information on the terms and conditions of coverage in easily understandable language including, but not limited to, information on the following:

(i) Coverage provisions, benefits, limitations, exclusions and restrictions on the use of any providers of care;

(ii) Summary of utilization review and quality assurance policies; and

(iii) Enrollee financial responsibility for copayments, deductibles and payments for out-of-plan services or supplies;

(b) Demonstrate that its provider network has providers

of sufficient number throughout the service area to assure reasonable access to care with minimum inconvenience by plan enrollees;

(c) File a summary of the plan credentialing criteria and process and policies with the State Department of Insurance to be available upon request;

(d) Provide a participating provider with a copy of his/her individual profile if economic or practice profiles, or both, are used in the credentialing process upon request;

(e) When any provider application for participation is denied or contract is terminated, the reasons for denial or termination shall be reviewed by the managed care plan upon the request of the provider; * * *

(f) Establish procedures to ensure that all applicable state and federal laws designed to protect the confidentiality of medical records are followed;

(g) Require participating providers in the plan, before providing any patient enrolled in the plan with any hospital, medical or other health care service that requires precertification before the plan will reimburse for that service, to verify that the patient has obtained the required precertification for that service or, if not done by the patient, to obtain the required precertification for the patient.

SECTION 2. Section 25-15-9, Mississippi Code of 1972, is amended as follows:

25-15-9. (1) (a) The department shall design a plan of health insurance for state employees which provides benefits for semiprivate rooms in addition to other incidental coverages which the department deems necessary. The amount of the coverages shall be in such reasonable amount as may be determined by the department to be adequate, after due consideration of current health costs in Mississippi. The plan shall also include major medical benefits in such amounts as the department shall determine. The plan shall require providers that participate in

the plan or in any network established under the plan, before providing any patient enrolled in the plan or network with any hospital, medical or other health care service that requires precertification before the plan will reimburse for that service, to verify that the patient has obtained the required precertification for that service or, if not done by the patient, to obtain the required precertification for the patient. The department is also authorized to accept bids for such alternate coverage and optional benefits as the department shall deem proper. The department may employ or contract for such consulting or actuarial services as may be necessary to formulate the State Employees Health Insurance Plan, and to assist the department in the preparation of specifications and in the process of advertising for the bids for the plan. The department is authorized to promulgate rules and regulations to implement the provisions of this subsection.

The department shall develop plans for the insurance plan authorized by this section in accordance with the provisions of Section 25-15-5.

(b) There is created an advisory council to advise the department in the formulation of the State Employees Health Insurance Plan. The council shall be composed of the State Insurance Commissioner or his designee, an employee-representative of the institutions of higher learning appointed by the board of trustees thereof, an employee-representative of the Department of Transportation appointed by the director thereof, an employee-representative of the State Tax Commission appointed by the Commissioner of Revenue, an employee-representative of the Mississippi Department of Health appointed by the State Health Officer, an employee-representative of the Mississippi Department of Corrections appointed by the Commissioner of Corrections, and an employee-representative of the Department of Human Services appointed by the Executive Director of Human Services.

The Lieutenant Governor may designate the Secretary of the

Senate, the Chairman of the Senate Appropriations Committee and the Chairman of the Senate Insurance Committee, and the Speaker of the House of Representatives may designate the Clerk of the House, the Chairman of the House Appropriations Committee and the Chairman of the House Insurance Committee, to attend any meeting of the State Employees Insurance Advisory Council. The appointing authorities may designate an alternate member from their respective houses to serve when the regular designee is unable to attend such meetings of the council. Such designees shall have no jurisdiction or vote on any matter within the jurisdiction of the council. For attending meetings of the council, such legislators shall receive per diem and expenses which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the council will be paid while the Legislature is in session. No per diem and expenses will be paid except for attending meetings of the council without prior approval of the proper committee in their respective houses.

(c) No change in the terms of the State Employees Health Insurance Plan may be made effective unless the Executive Director of the Department of Finance and Administration, or his designee, has provided notice to the State Employees Health Insurance Advisory Council and has called a meeting of the council at least fifteen (15) days before the effective date of such change. In the event that the State Employees Health Insurance Council does not meet to advise the department on the proposed changes, the changes to the plan shall become effective at such time as the department has informed the council that the changes shall become effective.

(d) **Medical benefits for retired employees and dependents under age sixty-five (65) years.** The same health insurance coverage as for all other active employees and their dependents shall be available to retired employees and all

dependents under age sixty-five (65) years, the level of benefits to be the same level as for all other active participants. This section will apply to those employees who retire due to one hundred percent (100%) medical disability as well as those employees electing early retirement.

(e) **Medical benefits for retired employees over age sixty-five (65) years.** The health insurance coverage available to retired employees over age sixty-five (65) years, and all dependents over age sixty-five (65) years, shall be the major medical coverage with the lifetime maximum of One Million Dollars ($1,000,000.00). Benefits shall be reduced by Medicare benefits as though such Medicare benefits were the base plan.

All covered individuals shall be assumed to have full Medicare coverage, Parts A and B; and any Medicare payments under both Parts A and B shall be computed to reduce benefits payable under this plan.

(2) Nonduplication of benefits--reduction of benefits by Title XIX benefits: When benefits would be payable under more than one (1) group plan, benefits under those plans will be coordinated to the extent that the total benefits under all plans will not exceed the total expenses incurred.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable in accordance with Title XIX of the Social Security Act or under any amendments thereto, or any implementing legislation.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable by workers' compensation. (3) Schedule of life insurance benefits--group term: The amount of term life insurance for each active employee shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and

dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee becomes totally and permanently disabled prior to age sixty-five (65) years. Retired employees shall be eligible to continue life insurance coverage in an amount of Two Thousand Dollars ($2,000.00), Four Thousand Dollars ($4,000.00) or Ten Thousand Dollars ($10,000.00) into retirement. The Department of Finance and Administration shall prepare a report to the Legislative Budget Office on or before October 1, 1995, recommending any changes to the maximum group life coverages applicable to retired employees prescribed herein, and providing options as to any expected additional costs associated with increasing such benefits.

(4) Any eligible employee who on March 1, 1971, was participating in a group life insurance program which has provisions different from those included herein and for which the State of Mississippi was paying a part of the premium may, at his discretion, continue to participate in such plan. Such employee shall pay in full all additional costs, if any, above the minimum program established by this article. Under no circumstances shall any individual who begins employment with the state after March 1, 1971, be eligible for the provisions of this paragraph.

(5) Any participant of the State Employees Health Insurance Plan who otherwise would lose coverage and who would be eligible as a dependent under an existing Public School Employees Health Insurance Plan contract may transfer to the Public School Employees Health Insurance Plan as a dependent under the existing contract. Any participant of the Public School Employees Health Insurance Plan who otherwise would lose coverage and who would be eligible as a dependent under an existing State Employees Health Insurance Plan contract may transfer to the State Employees Health Insurance Plan as a dependent under the existing contract. A transfer pursuant to this subsection must occur within thirty-one (31) days of losing coverage. Credit shall be given for any

deductible amount satisfied, out-of-pocket expenses and time served toward the twelve-month pre-existing waiting period.

(6) If both spouses are eligible employees who participate in the plan, the benefits shall apply individually to each spouse by virtue of his or her participation in the plan. If those spouses also have one or more eligible dependents participating in the plan, the cost of their dependents shall be calculated at a special family plan rate. The cost for participation by the dependents shall be paid by the spouse who elects to carry such dependents under his or her coverage. The special family plan rate shall also apply if the state employee's spouse is a covered eligible employee under the Public School Employees Health Insurance Plan.

(7) (a) The department may offer medical savings accounts as defined in Section 71-9-3 as a plan option. Provided, however, that prior to offering such accounts as a plan option, the Department of Finance and Administration shall prepare and present to the Senate and House Insurance Committees by December 15, 1996, a comprehensive study of medical savings accounts to include a proposed implementation timetable and potential actuarial effects of such accounts on the existing state employee health plan. The department's study shall also include, but not be limited to, recommended employer contribution levels, recommended employee contribution levels, recommendations on annual rollover of balances or withdrawals for nonmedical purposes, and recommendations on medical coverage for persons who expend their account balances. The department shall use existing staff resources and those of other agencies to conduct this study. In no case shall the department employ a consultant or contractor other than an actuary to conduct this study. No later than July 15, 1996, the Department of Finance and Administration shall meet with the staff of the PEER Committee and the Legislative Budget Office to receive recommendations on the issues and methods which the department shall consider in preparing its report. No later

than October 15, 1996, the Department of Finance and Administration shall submit a copy of its draft report to the PEER Committee and the Legislative Budget Office which shall analyze the report and prepare comments for publication in the final report to be submitted to the House and Senate Insurance Committees on December 15, 1996.

(b) In no case shall the department offer medical savings accounts as an option to health plan participants prior to January 1, 1998.

(8) Any premium differentials, differences in coverages, discounts determined by risk or by any other factors shall be uniformly applied to all active employees participating in the insurance plan. It is the intent of the Legislature that the state contribution to the plan be the same for each employee throughout the state.

SECTION 3. Section 25-15-255, Mississippi Code of 1972, is amended as follows:

25-15-255. (1) (a) The Department of Finance and Administration shall design a plan of health insurance for employees which provides benefits for semiprivate rooms in addition to other incidental coverages which the department deems necessary.

The amount of the coverages shall be in such reasonable amount as may be determined by the department to be adequate, after due consideration of current health costs in Mississippi. The plan shall also include major medical benefits in such amounts as the department shall determine. <u>The plan shall require providers that participate in the plan or in any network established under the plan, before providing any patient enrolled in the plan or network with any hospital, medical or other health care service that requires precertification before the plan will reimburse for that service, to verify that the patient has obtained the required precertification for that service or, if not done by the patient, to obtain the required precertification for</u>

the patient. The department is also authorized to accept bids for alternate coverage and optional benefits. Any contract for alternative coverage and optional benefits shall be awarded by the department after it has carefully studied and evaluated the bids and selected the best and most cost-effective bid. The department may reject all such bids; however, the department shall notify all bidders of the rejection and shall actively solicit new bids if all bids are rejected.

It is the intent of the Legislature that coverage under this plan may be self-insured by the State of Mississippi and the same as coverage provided state employees under the Public Employees Health Insurance Plan created in Section 25-15-3 et seq. The department may contract the administration and service of the self-insured program to a third party; however, before executing any contract, the department shall actively solicit bids for the administration and service of the program.

The department shall conduct the solicitation and contracting process in strict accordance with Section 25-15-301.

Beginning on January 1, 1996, any contract entered into between the department for the administration and/or service of the self-insured plan and a third party shall be for the calendar year that begins on the first day of January and expires on the following thirty-first day of December.

The department may employ or contract for such consulting or actuarial services as may be necessary to formulate the Public School Employees Health Insurance Plan, and to assist the department in the preparation of specifications and in the process of advertising for the bids for the plan. Such contracts shall be solicited and entered into in accordance with Section 25-15-5. The department shall keep a record of all persons, agents and corporations who contract with or assist the department in preparing and developing the plan. The department, in a timely manner, shall provide copies of this record to the members of the advisory council created in paragraph (b) of this subsection and

those legislators, or their designees, who may attend meetings of the advisory council. The department shall provide copies of this record in the solicitation of bids for the administration and servicing of the self-insured program. Each person, agent or corporation which, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and which bids on the administration or servicing of the plan, shall submit to the department a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The department shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the department on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid.

The department is authorized to promulgate rules and regulations to implement the provisions of this subsection. After expiration or termination of the contract between the state and the administering corporation existing immediately before the date on which the plan becomes self-insured by the State of Mississippi, the remainder of funds in the Premium Stabilization Fund shall revert to the Public School Employees Insurance Fund and shall be used exclusively for payment of future premiums.

Any corporation, association, company or individual that contracts with the department for the third-party claims administration of the self-insured plan shall prepare and keep on file an explanation of benefits for each claim processed. The explanation of benefits shall contain such information relative to each processed claim which the department deems necessary, and at

a minimum, each explanation shall provide the claimant's name, claim number, provider number, provider name, service dates, type of services, amount of charges, amount allowed to the claimant and reason codes.

The information contained in the explanation of benefits shall be available for inspection upon request by the department. The department shall have access to all claims information utilized in the issuance of payments to employees and providers. Any corporation, association, company or individual that contracts with the department for the administration and/or service of the self-insured plan shall remit one hundred percent (100%) of all savings or discounts resulting from any contract to the department and/or participant. Any corporation, association, company or individual that contracts with the department for the administration and/or service of the self-insured plan shall allow, upon notice by the department, the department or its designee to audit records of the corporation, association, company or individual relative to the corporation, association, company or individual's performance under any contract with the department. The information maintained by any corporation, association, company or individual, relating to such contracts, shall be available for inspection upon request by the department and such information shall be compiled in a manner that will provide a clear audit trail.

(b) There is created an advisory council to the department to advise the department in the formulation of the Public School Employees Health Insurance Plan. The advisory council and those legislators, or their designees, authorized to attend meetings of the advisory council pursuant to this subsection shall be informed in a timely manner concerning each aspect of the formulation and development of the plan. No change in the terms of the Public School Employees Health Insurance Plan may be made effective unless the Executive Director of the Department of Finance and Administration, or his designee, has

provided notice to the Public School Employees Health Insurance Advisory Council and has called a meeting of the council at least fifteen (15) days before the effective date of such change. In the event that the Public School Employees Health Insurance Advisory Council does not meet to advise the department on the proposed changes, the changes to the plan shall become effective at such times as the department has informed the council that the changes shall become effective.

The council shall be composed of the State Insurance Commissioner or his designee, two (2) certificated public school administrators appointed by the State Board of Education, two (2) certificated classroom teachers appointed by the State Board of Education, a noncertificated school employee appointed by the State Board of Education, and a community/junior college employee appointed by the State Board for Community and Junior Colleges. Members of the council shall serve at the will and pleasure of the appointing authorities; however, no member shall serve for a period of less than one (1) year. The members of the council shall serve without compensation, per diem or expense reimbursement.

The Chairman of the Senate Insurance Committee, the Chairman of the Senate Education Committee, the Chairman of the House of Representatives Insurance Committee and the Chairman of the House of Representatives Education Committee, and/or their designees from their respective houses, may attend any meeting of the advisory council. The legislators, or their designees, shall have no jurisdiction or vote on any matter within the jurisdiction of the council. For attending meetings of the council, the legislators shall receive per diem and expenses which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the council will be paid while the Legislature is in session. No per diem and expenses will be paid

except for attending meetings of the council without prior approval of the proper committee in their respective houses.

(c) **Medical benefits for retired employees and dependents under age sixty-five (65) years.** The same health insurance coverage as for all other active employees and their dependents shall be available to retired employees and all dependents under age sixty-five (65) years, the level of benefits to be the same level as for all other active participants. This section will apply to those employees who retire due to one hundred percent (100%) medical disability as well as those employees electing early retirement.

(d) **Medical benefits for retired employees over age sixty-five (65)**. The health insurance coverage available to retired employees over age sixty-five (65) years, and all dependents over age sixty-five (65) years, shall be the major medical coverage with the lifetime maximum of One Million Dollars ($1,000,000.00). Benefits shall be reduced by Medicare benefits as though such Medicare benefits were the base plan.

All covered individuals shall be assumed to have full Medicare coverage, Parts A and B; and any Medicare payments under both Parts A and B shall be computed to reduce benefits payable under this plan.

(2) **Nonduplication of benefits-reduction of benefits by Title XIX benefits.** When benefits would be payable under more than one group plan, benefits under those plans will be coordinated to the extent that the total benefits under all plans will not exceed the total expenses incurred.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable in accordance with Title XIX of the Social Security Act or under any amendments thereto, or any implementing legislation.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable by workers' compensation.

(3) The department is hereby authorized to determine the manner in which premiums and contributions by the state and local school districts shall be collected to provide the self-insured health insurance program for school employees and community/junior college employees as provided under this article.

(4) Any premium differentials, differences in coverages, discounts determined by risk or by any other factors shall be uniformly applied to all active employees participating in the insurance plan. It is the intent of the Legislature that the state contribution to the plan be the same for each employee throughout the state.

(5) Any participant of the State Employees Health Insurance Plan who otherwise would lose coverage and who would be eligible as a dependent under an existing Public School Employees Health Insurance Plan contract may transfer to the Public School Employees Health Insurance Plan as a dependent under the existing contract. Any participant of the Public School Employees Health Insurance Plan who otherwise would lose coverage and who would be eligible as a dependent under an existing State Employees Health Insurance Plan contract may transfer to the State Employees Health Insurance Plan as a dependent under the existing contract. A transfer pursuant to this subsection must occur within thirty-one (31) days of losing coverage. Credit shall be given for any deductible amount satisfied, out-of-pocket expenses and time served toward the twelve-month pre-existing waiting period.

(6) The Department of Finance and Administration shall annually report to the Joint Legislative Budget Committee the condition of the Public School Employees Health Insurance Plan. Such report shall contain, but not be limited to, a report of the plan's financial condition at the close of the most recent complete calendar year. The report shall also include all recommendations made to the department by consultants regarding the plan and its administration, including a complete departmental response to each recommendation. The department shall also list

the history of yearly claims paid and premiums received for each employee subgroup, including, but not limited to, active employees, dependents and retirees and shall also publish the loss ratios for these subgroups. For purposes of this subsection, the term "loss ratios" shall mean claims paid by the plan for each subgroup divided by premiums received by the plan for the insurance coverage of the members in that subgroup. Any plan revisions made during the previous year shall also be listed in the report and fully described in the report. The department shall also provide the Joint Legislative Budget Committee with a monthly statement of plan utilization.

In addition to the information provided for herein, the department shall provide to the Joint Legislative Budget Committee budgetary information on the Public School Employees Health Insurance Plan. All information shall be provided to the Joint Legislative Budget Committee in a format designated by the committee. The information shall be provided in September of each year, and at such times throughout the year as the committee deems necessary. The information shall include, but not be limited to:

(a) A detailed breakdown of all expenditures of the plan, administrative and otherwise, for the most recently completed fiscal year and projected expenditures for the current fiscal year;

(b) A schedule of all contracts, administrative and otherwise, executed for the benefit of the plan during the most recent completed fiscal year, and those executed and anticipated for the current fiscal year;

(c) Anticipated plan expenditures, administrative and otherwise, for the next fiscal year.

The department shall also provide to the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER) all information described in paragraph (b) in this subsection. The PEER Committee shall prepare a report by January 1 of each year on all contractors utilized by the department for the health

plans, excluding the third-party administrator contract. The committee's report shall address the processes by which the department procured the contractors, the contractors' work products and contract expenditures. The review provided for herein shall be supplemental to the review provided for in Section 25-15-301.

(7) (a) The department may offer medical savings accounts as defined in Section 71-9-3 as a plan option. Provided, however, that prior to offering such accounts as a plan option, the Department of Finance and Administration shall prepare and present to the Legislature by December 15, 1996, a comprehensive study of medical savings accounts to include a proposed implementation timetable and potential actuarial effects of such accounts on the existing public school employees' health plan. The department's study shall also include, but not be limited to, recommended employer contribution levels, recommended employee contribution levels, recommendations on annual rollover of balances or withdrawals for nonmedical purposes, and, recommendations on medical coverage for persons who expend their account balances. The department shall use existing staff resources and those of other agencies to conduct this study. In no case shall the department employ a consultant or contractor other than an actuary to conduct this study. No later than July 15, 1996, the Department of Finance and Administration shall meet with the staff of the PEER Committee and the Legislative Budget Office to receive recommendations on the issues and methods which the department shall consider in preparing its report. No later than October 15, 1996, the Department of Finance and Administration shall submit a copy of its draft report to the PEER Committee and the Legislative Budget Office which shall analyze the report and prepare comments for publication in the final report to be submitted to the House and Senate Insurance Committees on December 15, 1996.

(b) In no case shall the department offer medical savings accounts as an option to health plan participants prior to

January 1, 1998.

SECTION 4. This act shall take effect and be in force from and after its passage.