MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Senator(s) Jordan (24th)

To: Public Health and Welfare

SENATE BILL NO. 2064
(As Passed the Senate)

AN ACT TO AMEND SECTIONS 83-41-303 AND 83-41-315, MISSISSIPPI CODE OF 1972, TO PROHIBIT HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACTS FROM REQUIRING PRIOR AUTHORIZATION FOR EMERGENCY SERVICES; TO CODIFY SECTION 83-41-410, MISSISSIPPI CODE OF 1972, TO PROHIBIT MANAGED CARE PLANS, HEALTH MAINTENANCE ORGANIZATIONS AND OTHER CONTRACTORS FOR PROVIDING HEALTH SERVICES FROM RESTRICTING THE DISCLOSURE OF TREATMENT ALTERNATIVES TO SUBSCRIBERS; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 83-41-303, Mississippi Code of 1972, is amended as follows:

83-41-303. (a) "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services and includes, but is not limited to, mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment for the purpose of preventing, alleviating, curing or healing human illness or physical disability.

(b) "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. Capitated basis includes the cost associated with operating staff model facilities.

(c) "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, fraternal societies, preferred provider organizations or any other

entity responsible for the payment of benefits or provision for services under a group contract or individual contract on a prepayment basis.

(d) "Commissioner" means the Commissioner of Insurance.

(e) "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

(f) "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the carrier begins to be responsible for the costs associated with treatment.

(g) "Emergency care benefits and services" means, with respect to an enrollee, covered inpatient and outpatient care benefits and services that (i) are furnished by a provider that is qualified to furnish such services, and (ii) are needed to evaluate or stabilize an emergency medical condition.

(h) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(i) "Enrollee" means an individual who is covered for the benefits offered by the carrier.

(j) "Evidence of coverage" means a statement of the essential features and services of the health care provider which is given to the subscriber by the carrier or by the group contract holder.

(k) "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee or subscriber who is totally disabled on the date of termination.

(l) "Financing" means the prepayment of premium or premium equivalences for services to be received by the enrollee in the future together with acceptance and assumption of the risk,

including capitation fee.

(m) "Grievance" means a written complaint submitted in accordance with the provider's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the carrier or provider to the enrolled.

(n) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group and may include coverage for dependents.

(o) "Group contract holder" means a person having a group contract.

(p) "Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services through an organized system which combines the delivery and financing of health care to enrollees on a prepaid or other financial basis (except for enrolled responsibility for copayment or deductibles) through an organized system which combines the delivery and financing of health care. When an organization accepts and assumes risks and accepts payments, fees, premiums or premium equivalences or that risk it is deemed to be a health maintenance organization.

(q) "Health maintenance organization producer" means a person who holds a life, health and accident insurance license and a certificate of authority to represent the health maintenance organization who solicits, negotiates, effects, procures,

delivers, renews or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself, or a person who advertises or otherwise holds himself out to the public as such.

(r) "Individual contract" means a contract for health care services issued to and covering an individual may include dependents of the subscriber.

(s) "Insolvent" or "insolvency" means that the organization

has been declared insolvent and placed under an order of rehabilitation or liquidation by a court of competent jurisdiction.

(t) "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

(u) "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

(v) "Participating provider" means a provider as defined in paragraph (x) who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

(w) "Person" means any natural or artificial person including, but not limited to, individuals, partnerships, associations, trusts, fraternal societies or corporations.

(x) "Provider" means any physician, hospital or other person licensed or otherwise authorized to furnish health care services.

(y) "Replacement coverage" means the benefits provided by a succeeding carrier.

(z) "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

(aa) "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable if the health maintenance organization is insolvent and for which no alternative arrangements have been

made that are acceptable to the commissioner.

SECTION 2. Section 83-41-315, Mississippi Code of 1972, is amended as follows:

83-41-315. (1) (a) Every group and individual contract holder is entitled to a group or individual written contract respectively.

(b) The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by the Unfair Trade Practices Act.

(c) The contract shall contain a clear statement of the following:

(i) Name and street address of the physical location of the home office of the health maintenance organization and telephone number;

(ii) Eligibility requirements;

(iii) Benefits and services within the service area;

(iv) Emergency care benefits and services;

(v) Out of area benefits and services (if any);

(vi) Copayments, deductibles or other out-of-pocket expenses;

(vii) Limitations and exclusions;

(viii) Enrollee termination;

(ix) Enrollee reinstatement (if any);

(x) Claims procedures;

(xi) Enrollee grievance procedures;

(xii) Continuation of coverage;

(xiii) Conversion;

(xiv) Extension of benefits (if any);

(xv) Coordination of benefits (if applicable);

(xvi) Subrogation (if any);

(xvii) Description of the service area;

(xviii) Entire contract provision;

(xix) Term of coverage;

(xx) Cancellation of group or individual contract holder;

(xxi) Renewal;

(xxii) Reinstatement of group or individual contract holder (if any);

(xxiii) Grace period; and

(xxiv) Conformity with state law, including, but not limited to, Section 83-9-1 et seq., Mississippi Code of 1972.

(2) The contract shall contain a provision that emergency care benefits and services, ambulance, medical screening, examination and evaluation, and stabilizing treatment, will be provided without regard to prior authorization and regardless of whether such benefits and services are provided by a non-participating provider.

(3) In addition to those provisions required in subsection (1)(c), an individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded. If services were received during the ten-day period, and the person returns the contract to receive a refund of the premium paid, he or she must pay for the services.

(4) (a) Every subscriber shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

(b) The evidence of coverage shall not contain provisions or statements which are unfair, unjust, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by Unfair Trade Practices Act.

(c) The evidence of coverage shall contain a clear statement of the provisions required in subsection (1)(c).

(5) The commissioner may adopt regulations establishing readability standards for individual contract, group contract, and

evidence of coverage forms.

(6) No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed and the proper fees paid with and approved by the commissioner, subject to subsections (7) and (8) of this section.

(7) If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the commissioner of this state for approval though it cannot be offered in this state without approval of the commissioner.

(8) Every form required by this section shall be filed for approval with the commissioner. At any time, after thirty (30) days' notice and for cause shown, the commissioner may withdraw approval of any form, effective at the end of the thirty (30) days. When a filing is disapproved or approval of a form is withdrawn, the commissioner shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within thirty (30) days of receipt of the notice the health maintenance organization may request a hearing. A hearing will be conducted within thirty (30) days after the commissioner has received the request for hearing.

(9) The commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

SECTION 3. The following provision shall be codified as Section 83-41-410, Mississippi Code of 1972:

83-41-410. (1) No managed care plan, health maintenance organization, independent practice association, other entity contracting for the provision of health care services, or any

other entity, shall prohibit or restrict any participating provider from disclosing to any subscriber, enrollee or member any medically appropriate health care information that such participating provider deems appropriate regarding (a) the nature of treatment, risks or alternatives thereto; (b) the availability of alternate therapies, consultation or tests; (c) the decision of any plan to authorize or deny services; or (d) the process the plan or any person contracting with the plan uses, or proposes to use, to authorize or deny health care services or benefits. Any such prohibition or restriction contained in a contract with a participating provider shall be void and unenforceable.

(2) Upon the application and rendering by any managed care entity of a decision to terminate an employment or other contractual relationship with or otherwise penalize a participating physician, surgeon or medical provider, that entity shall be prohibited from denying such an application or terminating that relationship principally for advocating medically appropriate health care that is consistent with that degree of learning and skill ordinarily possessed by reputable physicians, surgeons and medical providers practicing according to the applicable legal standard of care.

(3) This section shall not be construed to prohibit a managed care plan from making a determination not to pay for a particular medical treatment or service, or to prohibit a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff, hospital governing body, or payor from enforcing reasonable peer review or utilization review protocols or determining whether a physician, surgeon or medical provider has complied with those protocols.

(4) For the purpose of this section, "to advocate medically appropriate health care" shall mean to appeal a payor's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent

practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payor as required by Section 41-83-1 et seq., Mississippi Code of 1972, or to protest a decision policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients.

SECTION 4. This act shall take effect and be in force from and after July 1, 1999.