

By: Moody

To: Insurance

HOUSE BILL NO. 1314

1 AN ACT TO AMEND SECTION 83-41-403, MISSISSIPPI CODE OF 1972,
2 TO TRANSFER THE RESPONSIBILITY FOR THE ADMINISTRATION OF THE
3 PATIENT PROTECTION ACT FROM THE MISSISSIPPI DEPARTMENT OF
4 INSURANCE TO THE MISSISSIPPI STATE DEPARTMENT OF HEALTH; TO
5 INCLUDE PREFERRED PROVIDER ORGANIZATIONS IN THE DEFINITION OF
6 MANAGED CARE ENTITIES; TO AMEND SECTION 83-41-409, MISSISSIPPI
7 CODE OF 1972, TO PROVIDE CERTAIN CONDITIONS FOR CERTIFICATION OF
8 MANAGED CARE PLANS; AND FOR RELATED PURPOSES.

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

10 SECTION 1. Section 83-41-403, Mississippi Code of 1972, is
11 amended as follows:[RDD1]

12 83-41-403. (1) As used in this article:

13 (a) "Department" means the Mississippi State Department
14 of Health.

15 (b) "Managed care plan" means a plan operated by a
16 managed care entity as described in subparagraph (c) that provides
17 for the financing and delivery of health care services to persons
18 enrolled in such plan through:

19 (i) Arrangements with selected providers to
20 furnish health care services;

21 (ii) Explicit standards for the selection of
22 participating providers;

23 (iii) Organizational arrangements for ongoing
24 quality assurance, utilization review programs and dispute
25 resolution; and

26 (iv) Financial incentives for persons enrolled in
27 the plan to use the participating providers, products and
28 procedures provided for by the plan.

29 (c) "Managed care entity" includes, but is not limited

30 to, a licensed insurance company, hospital or medical service
31 plan, health maintenance organization (HMO), preferred provider
32 organization (PPO), an employer or employee organization, or a
33 managed care contractor as described in subparagraph (d) that
34 operates a managed care plan, and any other type of plan or entity
35 that acts or appears like any of the plans or entities described
36 in this paragraph.

37 (d) "Managed care contractor" means a person or
38 corporation that:

39 (i) Establishes, operates or maintains a network
40 of participating providers;

41 (ii) Conducts or arranges for utilization review
42 activities; and

43 (iii) Contracts with an insurance company, a
44 hospital or medical service plan, an employer or employee
45 organization, or any other entity providing coverage for health
46 care services to operate a managed care plan.

47 (e) "Participating provider" means a physician,
48 hospital, pharmacy, pharmacist, dentist, nurse, chiropractor,
49 optometrist, or other provider of health care services licensed or
50 certified by the state, that has entered into an agreement with a
51 managed care entity to provide services, products or supplies to a
52 patient enrolled in a managed care plan.

53 (2) In order to facilitate the transfer of necessary
54 information for the purpose of regulation, credentialing, and
55 standards of quality, the department and the Mississippi
56 Department of Insurance shall share and exchange data, standards,
57 regulatory information and other such information on a regular
58 basis.

59 SECTION 2. Section 83-41-409, Mississippi Code of 1972, is
60 amended as follows:[MS2]

61 83-41-409. In order to be certified and recertified under
62 this article, a managed care plan shall:

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

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

69 (ii) Summary of utilization review and quality
70 assurance policies, including an ongoing internal quality
71 assurance program to monitor and evaluate its health care
72 services, including primary and specialist physician services, and
73 ancillary and preventive health care services, across all
74 institutional and noninstitutional settings; and

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

78 (b) Demonstrate that its provider network has providers
79 of sufficient number throughout the service area to assure
80 reasonable access to care with minimum inconvenience by plan
81 enrollees;

82 (c) File a copy of the plan credentialing criteria and
83 process and policies with the department and the State Department
84 of Insurance * * *;

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

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

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

95 SECTION 3. This act shall take effect and be in force from

96 and after July 1, 2000.