MISSISSIPPI LEGISLATURE REGULAR SESSION 2002

By: Senator(s) Huggins

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2092

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

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

SECTION 1. Section 83-41-403, Mississippi Code of 1972, is amended as follows:

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

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

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

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

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

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

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

(c) "Managed care entity" includes, but is not limited to, a licensed insurance company, hospital or medical service

plan, health maintenance organization (HMO), preferred provider organization (PPO), an employer or employee organization, or a managed care contractor as described in subparagraph (d) that operates a managed care plan, and any other type of plan or entity that acts or appears like any of the aforementioned descriptions.

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

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

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

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

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

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

SECTION 2. 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, including an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services across all institutional and noninstitutional settings; 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 copy of the plan credentialing criteria and process and policies with the department and the State Department of Insurance * * *;

(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; and

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

SECTION 3. This act shall take effect and be in force from and after July 1, 2002.