MISSISSIPPI LEGISLATURE REGULAR SESSION 2006

By: Senator(s) Nunnelee

To: Public Health and Welfare

SENATE BILL NO. 2153

AN ACT TO AMEND SECTIONS 83-41-403, 83-41-405, 83-41-409, 83-41-411 AND 83-41-413, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT ALL TYPES OF PREFERRED PROVIDER ORGANIZATIONS (PPO), MANAGEMENT SERVICES ORGANIZATIONS (MSO), PHYSICIAN HOSPITAL ORGANIZATIONS (PHO) AND HEALTH ALLIANCES ARE SUBJECT TO THE CERTIFICATION REQUIREMENTS OF THE PATIENT PROTECTION ACT; TO PROVIDE DEFINITIONS; TO PROVIDE THAT SUCH ORGANIZATIONS SHALL COMPLY WITH CERTIFICATION REQUIREMENTS IN ADDITION TO OTHER LAWS; TO REQUIRE THE MISSISSIPPI DEPARTMENT OF INSURANCE TO ISSUE REGULATIONS EFFECTIVE JULY 1, 2006, TO IMPLEMENT THE PROVISIONS OF THIS ACT; 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. As used in this article:

(a) "Department" means the Mississippi Department of Insurance.

(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; * * *

(iv) Financial incentives for persons enrolled in the plan to use the participating providers, products and procedures provided for by the plan<u>; and</u>

(v) Any alternative delivery system plans designed as Preferred Provider Organizations (PPO), Health Maintenance Organizations (HMO), Management Services Organizations (MSO), Physician Hospital Organizations (PHO) and Health Alliances.

(c) "Managed care entity" includes a licensed insurance company, hospital or medical service plan, health maintenance organization (HMO), an employer or employee organization, or a managed care contractor as described in subsection (d) that operates a managed care plan.

(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.

(f) "Preferred Provider Organization (PPO)" means a managed care plan that contracts with independent providers at a discount for services, and shall include the following:

(i) A group of physicians and/or hospitals who contract with an employer to provide services to their employees; in a PPO the patient may visit the physician of his/her choice even if that physician does not participate in the PPO. The panel

is limited in size and has some type of utilization review system associated with it.

(ii) A PPO may be a risk-bearing insurance company or a nonrisk bearing plan that markets itself to insurance companies or self-insured companies through an access fee.

(g) "Management Services Organization (MSO)" means an arrangement where practice enhancement benefits are provided to physicians and physician groups. These services include materials, purchasing assistance, business office automation, billing, claims processing, and other administrative activity. A MSO may conduct any nonclinical aspect of a practice out of the physician's office.

(h) "Physician Hospital Organization (PHO)" means a legally recognized structure formed between health systems, health system affiliates and physicians. The PHO integrates the clinical, financial and administrative functions of both entities in order to provide a full range of services for purchasers of health care including health alliances and public group plans.

(i) "Health Alliance" means a purchasing group which collects premiums from employers and contracts with health care plans for large numbers of consumers, also referred to as a Health Insurance Purchasing Cooperative (HIPC).

SECTION 2. Section 83-41-405, Mississippi Code of 1972, is amended as follows:

83-41-405. The department shall establish a process for the certification of managed care plans, which shall include preferred provider organizations (PPO), health maintenance organizations (HMO), management service organizations (MSO), physician hospital organizations (PHO) and health alliances offered or provided to persons or providers residing in Mississippi. No such plan shall be offered or provided to persons residing in this state unless it has been certified by the department. Any managed care plan certified by the department must be recertified annually, and the

department shall establish procedures to ensure the continued compliance with the requirements of Section 83-41-409 through the recertification process. The department shall terminate the certificate of any managed care plan if such plan no longer meets the applicable requirements for certification. The department shall provide any such plan with an opportunity for a hearing on the proposed termination.

SECTION 3. 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 <u>as defined in Section 83-41-403</u> 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; and

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

SECTION 4. Section 83-41-411, Mississippi Code of 1972, is amended as follows:

83-41-411. Health maintenance organizations<u>, preferred provider organizations, management services organizations, physician hospital organizations and health alliances</u> must comply with the certification requirements in this article in addition to such other laws as might relate thereto.

SECTION 5. Section 83-41-413, Mississippi Code of 1972, is amended as follows:

83-41-413. The department shall adopt regulations <u>no later than July 1, 2006, to be effective January 1, 2007,</u> to implement the provisions of this article and may obtain any information from managed care plans that is necessary to determine if such plan should be certified or recertified.

SECTION 6. This act shall take effect and be in force from and after July 1, 2006.