MISSISSIPPI LEGISLATURE REGULAR SESSION 2017

By: Representative Currie

To: Insurance

HOUSE BILL NO. 337

AN ACT TO CREATE THE "MISSISSIPPI PATIENT PROTECTION ACT OF 2017"; TO DECLARE LEGISLATIVE INTENT; TO DEFINE CERTAIN TERMS USED IN THE ACT; TO PROVIDE THAT A HEALTH INSURER SHALL NOT DISCRIMINATE AGAINST ANY PROVIDER WHO IS LOCATED WITHIN THE GEOGRAPHIC COVERAGE AREA OF A HEALTH BENEFIT PLAN AND WHO IS WILLING TO MEET THE TERMS AND CONDITIONS FOR PARTICIPATION ESTABLISHED BY THE HEALTH INSURER; TO PROHIBIT A HEALTH INSURER FROM IMPOSING A MONETARY ADVANTAGE OR PENALTY THAT WOULD AFFECT A BENEFICIARY'S CHOICE AMONG THOSE HEALTH CARE PROVIDERS WHO PARTICIPATE IN THE HEALTH BENEFIT PLAN; TO REQUIRE THE COMMISSIONER OF INSURANCE TO ENFORCE THE STATE'S ANY WILLING PROVIDER LAWS; TO PROVIDE INJUNCTIVE RELIEF FOR VIOLATIONS OF THIS ACT; TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO ADOPT REGULATIONS TO IMPLEMENT THE ACT; TO AMEND SECTION 83-41-409, MISSISSIPPI CODE OF 1972, IN CONFORMITY THERETO; AND FOR RELATED PURPOSES.

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

SECTION 1. Sections 1 through 12 of this act shall be known and may be cited as the "Mississippi Patient Protection Act of 2017."

SECTION 2. The Legislature finds that a patient should be given the opportunity to see the health care provider of his or her choice. In order to assure the citizens of the State of Mississippi the right to choose a provider of their choice, it is

the intent of the Legislature to provide the opportunity for providers to participate in health benefit plans.

SECTION 3. As used in this act:

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

(b) "ERISA" means the federal Employee Retirement Income Security Act of 1974, as amended, 29 USCS Section 1001 et seq.

(c) "Health benefit plan" means (i) any health insurance policy or certificate, health maintenance organization contract, hospital and medical service corporation contract or certificate, self-insured plan or plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; or (ii) any health benefit plan that affects the rights of a Mississippi insured and bears a reasonable relation to the State of Mississippi, whether delivered or issued for delivery in the state; or (iii) the Mississippi State and School Employees Health Insurance Plan; or (iv) the Mississippi Medicaid Program established in Section 43-13-101 et seq. "Health benefit plan" does not include insurance arising out of a workers' compensation claim.

(d) "Health care provider" or "provider" means an individual or entity licensed by the State of Mississippi to provide health care services, limited to the following type of providers:

(i) Physicians and surgeons (M.D. and D.O.);

(ii) Podiatrists;

(iii) Chiropractors;

(iv) Physical therapists;

(v) Speech pathologists;

(vi) Audiologists;

(vii) Dentists;

(viii) Optometrists;

(ix) Hospitals;

(x) Hospital-based services;

(xi) Psychologists;

(xii) Licensed professional counselors;

(xiii) Respiratory therapists;

(xiv) Pharmacists;

(xv) Occupational therapists;

(xvi) Long-term care facilities;

(xvii) Home health care providers;

(xviii) Hospice care providers;

(xix) Licensed ambulatory surgery centers;

(xx) Rural health clinics;

(xxi) Licensed certified social workers;

(xxii) Licensed psychological examiners;

(xxiii) Advanced practice nurses;

(xxiv) Licensed dieticians;

(xxv) Community mental health centers or clinics;

(xxvi) Certified orthotists;

(xxvii) Prosthetists;

(xxviii) Licensed durable medical equipment providers; and

(xxix) Other health care practitioners as determined by the department in rules promulgated under the Mississippi Administrative Procedures Law, Section 25-43-101 et seq.

The term "health care provider" or "provider" includes independent clinical laboratories.

(e) "Health insurer" or "health care insurer" means any entity that is authorized by the State of Mississippi to offer or provide health benefit plans, policies, subscriber contracts or any other contracts of similar nature that indemnify or compensate health care providers for the provision of health care services.

(f) "Independent clinical laboratory" means a laboratory that is independent both of the attending or consulting physician's office and of a hospital, where microbiological, serological, chemical, hematological, biophysical, radiobioassay, cytological, immunohematological, immunological, pathological or other examinations are performed on materials derived from the human body, to provide information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

(g) "Any willing provider law" means a law that prohibits discrimination against a provider willing to meet the terms and conditions for participation established by a health

insurer, or that otherwise precludes an insurer from prohibiting or limiting participation by a provider who is willing to accept a health insurer's terms and conditions for participation in the provision of services through a health benefit plan.

(h) "Noninsurer" means an entity that is not required to obtain authorization from the department to do business as a health insurer but that does have a provider network.

(i) "Self-insured" includes self-funded and vice versa.

SECTION 4. A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer.

SECTION 5. Nothing in Sections 1 through 12 of this act shall be construed to require or prohibit the same reimbursement to different types of providers whose licensed scope of practice differs, nor shall anything in this act be construed to require or prohibit coverage of the services of any particular type of provider.

SECTION 6. (1) A health care insurer shall not, directly or indirectly:

(a) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those health care providers who participate in the health benefit plan according to the terms offered. "Monetary advantage or penalty" includes:

(i) A higher copayment;

(ii) A reduction in reimbursement for services; or

(iii) Promotion of one health care provider over another by these methods;

(b) Impose upon a beneficiary of health care services under a health benefit plan any copayment, fee or condition that is not equally imposed upon all beneficiaries in the same benefit category, class or copayment level under that health benefit plan when the beneficiary is receiving services from a participating health care provider under that health benefit plan; or

(c) Prohibit or limit a health care provider that is qualified under Sections 1 through 12 of this act and is willing to accept the health benefit plan's operating terms and conditions, schedule of fees, covered expenses and utilization regulations and quality standards, from the opportunity to participate in that plan.

(2) Nothing in Sections 1 through 12 of this act shall prevent a health benefit plan from instituting measures designed to maintain quality and to control costs, including, but not limited to, the utilization of a gatekeeper system, as long as those measures are imposed equally on all providers in the same class.

(3) Insurers shall establish relevant, objective standards for initial consideration of providers and for providers to continue as a participating provider in the plan. Standards shall

be reasonably related to service provided but not based solely on the volume of procedures performed by the provider. Selection or participation standards based on the economics or capacity of a provider's practice shall be adjusted to account for case mix, severity of illness, patient age and other features that may account for higher-than-or lower-than-expected costs. All data profiling or other data analysis pertaining to participating providers shall be done in a manner that is valid and reasonable. Plans shall not use criteria that would allow an issuer to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher-than-average claims, losses, or health services utilization or that would exclude providers because they treat or specialize in treating populations presenting a risk of higher-than-average claims, losses, or health services utilization.

SECTION 7. Any person adversely affected by a violation of the Sections 1 through 12 of this act may sue in a court of competent jurisdiction for injunctive relief against the health insurer.

SECTION 8. (1) A health benefit plan delivered or issued for delivery to any person in this state in violation of Sections 1 through 12 of this act but otherwise binding on the health insurer shall be held valid, but shall be construed as provided in Sections 1 through 12 of this act.

(2) Any health benefit plan or related policy, rider or endorsement issued and otherwise valid that contains any condition, omission or provision not in compliance with the requirements of Sections 1 through 12 of this act shall not be rendered invalid because of the noncompliance, but shall be construed and applied in accordance with that condition, omission or provision as would have applied if it had been in full compliance with Sections 1 through 12 of this act.

SECTION 9. The Commissioner of Insurance, acting through the department, shall:

(a) Enforce the state's any willing provider laws using powers granted to the commissioner in the Mississippi Insurance Code; and

(b) Be entitled to seek an injunction against a health insurer in a court of competent jurisdiction.

SECTION 10. (1) The state's any willing provider laws shall not be construed:

(a) To require all physicians or a percentage of physicians in the state or a locale to participate in the provision of services for a health maintenance organization; or

(b) To take away the authority of health maintenance organizations that provide coverage of physician services to set the terms and conditions for participation by physicians, though health maintenance organizations shall apply those terms and conditions in a nondiscriminatory manner.

(2) The state's any willing provider laws shall apply to:

(a) All health insurers, regardless of whether they are providing insurance, including pre-paid coverage, or administering or contracting to provide provider networks; and

(b) All multiple employer welfare arrangements and multiple employer trusts.

(3) Nothing in the state's any willing provider laws shall be construed to cover or regulate health care provider networks offered by noninsurers. If an employer sponsoring a self-insured health benefit plan contracts directly with providers or contracts for a health care provider network through a noninsurer, then the any willing provider law does not apply. If a health insurer subcontracts with a noninsurer whose health care network does not meet the requirements of the any willing provider law, then the noninsurer may, but is not required to, create a separate health care provider network that meets the requirements of the any willing provider law. If the noninsurer chooses not to create the separate health care provider network, then the responsibility for compliance with the any willing provider law is the obligation of the health insurer.

SECTION 11. The department shall adopt regulations to implement the provisions of Sections 1 through 12 of this act and may obtain any information from health benefit plans that is necessary to determine if the plan should be certified or enjoined.

SECTION 12. If any provision of this act or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION 13. 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 *** * ***; and

(g) Comply with all requirements of Sections 1 through 12 of this act.

SECTION 14. This act shall take effect and be in force from and after July 1, 2017.