By: Jordan To: Public Health and Welfare

SENATE BILL NO. 3114

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

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

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

12 83-41-303. (a) "Basic health care services" means the
13 following medically necessary services: preventive care,
14 emergency care, inpatient and outpatient hospital and physician
15 care, diagnostic laboratory and diagnostic and therapeutic
16 radiological services and includes, but is not limited to, mental
17 health services or services for alcohol or drug abuse, dental or
18 vision services or long-term rehabilitation treatment for the
19 purpose of preventing, alleviating, curing or healing human
20 illness or physical disability.

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

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

30 entity responsible for the payment of benefits or provision for
31 services under a group contract or individual contract on a
32 prepayment basis.
33 (d) "Commissioner" means the Commissioner of Insurance.
34 (e) "Copayment" means an amount an enrollee must pay in
35 order to receive a specific service which is not fully prepaid.
36 (f) "Deductible" means the amount an enrollee is responsible
37 to pay out-of-pocket before the carrier begins to be responsible
38 for the costs associated with treatment.
39 (g) "Emergency care benefits and services" means, with
40 respect to an enrollee, covered inpatient and outpatient care
41 benefits and services that (i) are furnished by a provider that is
42 qualified to furnish such services, and (ii) are needed to
43 evaluate or stabilize an emergency medical condition.
44 (h) "Emergency medical condition" means a medical condition
45 manifesting itself by acute symptoms of sufficient severity
46 (including severe pain) such that a prudent lay person, who
47 possesses an average knowledge of health and medicine, could
48 reasonably expect the absence of immediate medical attention to
49 result in (i) placing the health of the individual (or, with
50 respect to a pregnant woman, the health of the woman or her unborn
51 child) in serious jeopardy, (ii) serious impairment to bodily
52 functions, or (iii) serious dysfunction of any bodily organ or
53 part.
54 (i) "Enrollee" means an individual who is covered for the
55 benefits offered by the carrier.
56 (j) "Evidence of coverage" means a statement of the
57 essential features and services of the health care provider which
58 is given to the subscriber by the carrier or by the group contract
59 holder.
60 (k) "Extension of benefits" means the continuation of
61 coverage under a particular benefit provided under a contract
62 following termination with respect to an enrollee or subscriber
63 who is totally disabled on the date of termination.
64 (l) "Financing" means the prepayment of premium or premium
65 equivalences for services to be received by the enrollee in the
66 future together with acceptance and assumption of the risk,

67 including capitation fee.

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

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

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

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

87 (q) "Health maintenance organization producer" means a
88 person who holds a life, health and accident insurance license and
89 a certificate of authority to represent the health maintenance
90 organization who solicits, negotiates, effects, procures,
91 delivers, renews or continues a policy or contract for health
92 maintenance organization membership, or who takes or transmits a
93 membership fee or premium for such a policy or contract, other
94 than for himself, or a person who advertises or otherwise holds
95 himself out to the public as such.

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

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

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

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

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

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

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

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

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

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

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

133 made that are acceptable to the commissioner.

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

136 83-41-315. (1) (a) Every group and individual contract
137 holder is entitled to a group or individual written contract
138 respectively.

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

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

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

148 (ii) Eligibility requirements;

149 (iii) Benefits and services within the service
150 area;

151 (iv) Emergency care benefits and services;

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

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

155 (vii) Limitations and exclusions;

156 (viii) Enrollee termination;

157 (ix) Enrollee reinstatement (if any);

158 (x) Claims procedures;

159 (xi) Enrollee grievance procedures;

160 (xii) Continuation of coverage;

161 (xiii) Conversion;

162 (xiv) Extension of benefits (if any);

163 (xv) Coordination of benefits (if applicable);

164 (xvi) Subrogation (if any);

165 (xvii) Description of the service area;

166 (xviii) Entire contract provision;

167 (xix) Term of coverage;

168 (xx) Cancellation of group or individual contract

169 holder;

170 (xxi) Renewal;

171 (xxii) Reinstatement of group or individual

172 contract holder (if any);

173 (xxiii) Grace period; and

174 (xxiv) Conformity with state law, including, but

175 not limited to, Section 83-9-1 et seq., Mississippi Code of 1972.

176 (2) The contract shall contain a provision that emergency

177 care benefits and services, ambulance, medical screening,

178 examination and evaluation, and stabilizing treatment, will be

179 provided without regard to prior authorization and regardless of

180 whether such benefits and services are provided by a

181 non-participating provider.

182 (3) In addition to those provisions required in subsection

183 (1)(c), an individual contract shall provide for a ten-day period

184 to examine and return the contract and have the premium refunded.

185 If services were received during the ten-day period, and the

186 person returns the contract to receive a refund of the premium

187 paid, he or she must pay for the services.

188 (4) (a) Every subscriber shall receive an evidence of

189 coverage from the group contract holder or the health maintenance

190 organization.

191 (b) The evidence of coverage shall not contain

192 provisions or statements which are unfair, unjust, inequitable,

193 misleading, deceptive, or which encourage misrepresentation as

194 defined by Unfair Trade Practices Act.

195 (c) The evidence of coverage shall contain a clear

196 statement of the provisions required in subsection (1)(c).

197 (5) The commissioner may adopt regulations establishing

198 readability standards for individual contract, group contract, and

199 evidence of coverage forms.

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

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

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

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

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

229 83-41-410. (1) No managed care plan, health maintenance
230 organization, independent practice association, other entity
231 contracting for the provision of health care services, or any

232 other entity, shall prohibit or restrict any participating
233 provider from disclosing to any subscriber, enrollee or member any
234 medically appropriate health care information that such
235 participating provider deems appropriate regarding (a) the nature
236 of treatment, risks or alternatives thereto; (b) the availability
237 of alternate therapies, consultation or tests; (c) the decision of
238 any plan to authorize or deny services; or (d) the process the
239 plan or any person contracting with the plan uses, or proposes to
240 use, to authorize or deny health care services or benefits. Any
241 such prohibition or restriction contained in a contract with a
242 participating provider shall be void and unenforceable.
243 (2) Upon the application and rendering by any managed care
244 entity of a decision to terminate an employment or other
245 contractual relationship with or otherwise penalize a
246 participating physician, surgeon or medical provider, that entity
247 shall be prohibited from denying such an application or
248 terminating that relationship principally for advocating medically
249 appropriate health care that is consistent with that degree of
250 learning and skill ordinarily possessed by reputable physicians,
251 surgeons and medical providers practicing according to the
252 applicable legal standard of care.
253 (3) This section shall not be construed to prohibit a
254 managed care plan from making a determination not to pay for a
255 particular medical treatment or service, or to prohibit a medical
256 group, independent practice association, preferred provider
257 organization, foundation, hospital medical staff, hospital
258 governing body, or payor from enforcing reasonable peer review or
259 utilization review protocols or determining whether a physician,
260 surgeon or medical provider has complied with those protocols.
261 (4) For the purpose of this section, "to advocate medically
262 appropriate health care" shall mean to appeal a payor's decision
263 to deny payment for a service pursuant to the reasonable grievance
264 or appeal procedure established by a medical group, independent

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

274 SECTION 4. This act shall take effect and be in force from
275 and after July 1, 2000.