

By: Senator(s) Nunnelee

To: Public Health and Welfare

SENATE BILL NO. 2691

1 AN ACT TO AMEND SECTIONS 83-41-403, 83-41-405, 83-41-409,
 2 83-41-411 AND 83-41-413, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT
 3 ALL TYPES OF PREFERRED PROVIDER ORGANIZATIONS (PPO), MANAGEMENT
 4 SERVICES ORGANIZATIONS (MSO), PHYSICIAN HOSPITAL ORGANIZATIONS
 5 (PHO) AND HEALTH ALLIANCES ARE SUBJECT TO THE CERTIFICATION
 6 REQUIREMENTS OF THE PATIENT PROTECTION ACT; TO PROVIDE
 7 DEFINITIONS; TO PROVIDE THAT SUCH ORGANIZATIONS SHALL COMPLY WITH
 8 CERTIFICATION REQUIREMENTS IN ADDITION TO OTHER LAWS; TO REQUIRE
 9 THE MISSISSIPPI DEPARTMENT OF INSURANCE TO ISSUE REGULATIONS
 10 EFFECTIVE JULY 1, 2005, TO IMPLEMENT THE PROVISIONS OF THIS ACT;
 11 AND FOR RELATED PURPOSES.

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

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

15 83-41-403. As used in this article:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

88 83-41-405. The department shall establish a process for the
89 certification of managed care plans, which shall include preferred
90 provider organizations (PPO), health maintenance organizations
91 (HMO), management service organizations (MSO), physician hospital
92 organizations (PHO) and health alliances offered or provided to
93 persons or providers residing in Mississippi. No such plan shall
94 be offered or provided to persons residing in this state unless it
95 has been certified by the department. Any managed care plan
96 certified by the department must be recertified annually, and the

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

104 **SECTION 3.** Section 83-41-409, Mississippi Code of 1972, is
105 amended as follows:

106 83-41-409. In order to be certified and recertified under
107 this article, a managed care plan as defined in Section 83-41-403
108 shall:

109 (a) Provide enrollees or other applicants with written
110 information on the terms and conditions of coverage in easily
111 understandable language including, but not limited to, information
112 on the following:

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

115 (ii) Summary of utilization review and quality
116 assurance policies; and

117 (iii) Enrollee financial responsibility for
118 copayments, deductibles and payments for out-of-plan services or
119 supplies;

120 (b) Demonstrate that its provider network has providers
121 of sufficient number throughout the service area to assure
122 reasonable access to care with minimum inconvenience by plan
123 enrollees;

124 (c) File a summary of the plan credentialing criteria
125 and process and policies with the State Department of Insurance to
126 be available upon request;

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

130 (e) When any provider application for participation is
131 denied or contract is terminated, the reasons for denial or
132 termination shall be reviewed by the managed care plan upon the
133 request of the provider; and

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

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

139 83-41-411. Health maintenance organizations, preferred
140 provider organizations, management services organizations,
141 physician hospital organizations and health alliances must comply
142 with the certification requirements in this article in addition to
143 such other laws as might relate thereto.

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

146 83-41-413. The department shall adopt regulations no later
147 than July 1, 2005, to be effective January 1, 2006, to implement
148 the provisions of this article and may obtain any information from
149 managed care plans that is necessary to determine if such plan
150 should be certified or recertified.

151 **SECTION 6.** This act shall take effect and be in force from
152 and after July 1, 2005.