FIRST REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED]

SENATE SUBSTITUTE NO. 2 FOR

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILLS NOS. 328 & 88

91ST GENERAL ASSEMBLY

0691S.07T 2001

AN ACT

To repeal sections 197.285, 354.603, 354.606, 376.383 and 376.406, RSMo 2000, relating to the regulation of managed care, and to enact in lieu thereof eight new sections relating to the same subject, with an effective date for certain sections.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 197.285, 354.603, 354.606, 376.383 and 376.406, RSMo 2000, are repealed and eight new sections enacted in lieu thereof, to be known as sections 197.285, 354.603, 354.606, 376.383, 376.384, 376.406, Section 1 and Section 2, to read as follows:

197.285. 1. Hospitals and ambulatory surgical centers shall establish and implement a written policy adopted by each hospital and ambulatory surgical center relating to the protections for employees who disclose information pursuant to subsection 2 of this section. This policy shall include a time frame for completion of investigations related to complaints, not to exceed thirty days, and a method for notifying the complainant of the disposition of the investigation. This policy shall be submitted to the department of health to verify implementation. At a minimum, such policy shall include the following provisions:

(1) No supervisor or individual with authority to hire or fire in a hospital or ambulatory surgical center shall prohibit employees from disclosing information pursuant to subsection 2 of this section;

(2) No supervisor or individual with authority to hire or fire in a hospital or ambulatory surgical center shall use or threaten to use his or her supervisory authority to knowingly

EXPLANATION — Matter enclosed in bold faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

discriminate against, dismiss, penalize or in any way retaliate against or harass an employee because the employee in good faith reported or disclosed any information pursuant to subsection 2 of this section, or in any way attempt to dissuade, prevent or interfere with an employee who wishes to report or disclose such information;

(3) Establish a program to identify a compliance officer who is a designated person responsible for administering the reporting and investigation process and an alternate person should the primary designee be implicated in the report.

2. This section shall apply to information disclosed or reported in good faith by an employee concerning:

(1) Alleged facility mismanagement or fraudulent activity;

(2) Alleged violations of applicable federal or state laws or administrative rules concerning patient care, patient safety or facility safety; or

(3) The ability of employees to successfully perform their assigned duties.

All information disclosed, collected and maintained pursuant to this subsection and pursuant to the written policy requirements of this section shall be accessible to the department of health at all times and shall be reviewed by the department of health at least annually. Complainants shall be notified of the department of health's access to such information and of the complainant's right to **[**appeal to the department of health**] notify the department of health of any information concerning alleged violations of applicable federal or state laws or administrative rules concerning patient care, patient safety or facility safety**.

3. Prior to any disclosure to individuals or agencies other than the department of health, employees wishing to make a disclosure pursuant to the provisions of this section shall first report to the individual or individuals designated by the hospital or ambulatory surgical center pursuant to subsection 1 of this section.

4. If the compliance officer, compliance committee or management official discovers credible evidence of misconduct from any source and, after a reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then the hospital or ambulatory surgical center shall report the existence of misconduct to the appropriate governmental authority within a reasonable period, but not more than seven days after determining that there is credible evidence of a violation.

5. Reports made to the department of health shall be subject to the provisions of section 197.477, provided that the restrictions of section 197.477 shall not be construed to limit the employee's ability to subpoena from the original source the information reported to the department pursuant to this section.

6. Each written policy shall allow employees making a report who wish to remain anonymous to do so, and shall include safeguards to protect the confidentiality of the employee

making the report, the confidentiality of patients and the integrity of data, information and medical records.

7. Each hospital and ambulatory surgical center shall, within forty-eight hours of the receipt of a report, notify the employee that his or her report has been received and is being reviewed.

[8. The enactment of this section shall become effective January 1, 2001.**]**

354.603. 1. A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable delay. In the case of emergency services, enrollees shall have access twenty-four hours per day, seven days per week. The health carrier's medical director shall be responsible for the sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by the director in accordance with the requirements of this section and by reference to any reasonable criteria, including but not limited to, provider-enrollee ratios by specialty, primary care provider-enrollee ratios, geographic accessibility, reasonable distance accessibility criteria for pharmacy and other services, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(1) In any case where the health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers, including local pharmacists, to the business or personal residence of enrollees. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under, especially rural areas, consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, **[**financial capability**]** and legal authority of its providers to furnish all contracted benefits to enrollees. **The provisions of this subdivision shall not be construed to require any health care provider to submit copies of such health care provider's income tax returns to a health carrier. A health carrier may require a health care provider to obtain audited financial statements if such health care provider received ten percent or more of the total medical expenditures made by the health carrier.**

(4) A health carrier shall make its entire network available to all enrollees unless a contract holder has agreed in writing to a different or reduced network.

2. **[**Beginning July 1, 1998,**]** A health carrier shall file with the director, in a manner and

form defined by rule of the department of insurance, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the **health** carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The **health** carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing. The access plan shall describe or contain at a minimum the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

(4) The health carrier's methods for assessing the health care needs of enrollees and their satisfaction with services;

(5) The health carrier's method of informing enrollees of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling enrollees to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, in the event of a reduction in service area or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the health carrier's insolvency or other modification or cessation of operations, and transferred to other **[**providers**]** **health care professionals** in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 354.600 to 354.636.

354.606. 1. A health carrier shall establish a mechanism by which the participating provider shall be notified on an ongoing basis of the specific covered health services for which the provider shall be responsible, including any limitations or conditions on services.

2. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for enrollees. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or a person, other than the health carrier or intermediary, acting on behalf of the enrollee for services provided pursuant to this agreement. This agreement shall not prohibit the provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to enrollees. This agreement shall not prohibit a provider, except for a health care professional who is employed full time on the staff of a health carrier and has agreed to provide service exclusively to that health carrier's enrollees and no others, and an enrollee from agreeing to continue services solely at the expense of the enrollee, as long as the provider has clearly informed the enrollee that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy; including, but not limited to, collecting from any insurance carrier providing coverage to a covered person."

3. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier's or intermediary's insolvency or other cessation of operations, covered services to enrollees shall continue through the period for which a premium has been paid to the health carrier on behalf of the enrollee or until the enrollee's discharge from an inpatient facility, whichever time is greater.

4. The contract provisions satisfying the requirements of subsections 2 and 3 of this section shall:

(1) Be construed in favor of the enrollee;

(2) Survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier; and

(3) Supersede any oral or written contrary agreement between a provider and an enrollee or the representative of an enrollee if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by subsections 2 and 3 of this section.

5. In no event shall a participating provider collect or attempt to collect from an enrollee

any money owed to the provider by the health carrier nor shall a participating provider collect or attempt to collect from an enrollee any money in excess of the coinsurance, co-payments or deductibles. Failure of a health carrier to make timely payment of an amount owed to a provider in accordance with the provider's contract shall constitute an unfair claims settlement practice subject to sections 375.1000 to 375.1018, RSMo.

6. (1) A health carrier shall develop selection standards for participating primary care professionals and each participating health care professional specialty. Such standards shall be in writing and used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. Selection criteria shall not be established in a manner that will:

(a) Allow a health carrier to avoid a high-risk population by excluding a provider because such provider is located in a geographic area that contains a population presenting a risk of higher than average claims, losses or health services utilization; or

(b) Exclude a provider because such provider treats or specializes in treating a population presenting a risk of higher than average claims, losses or health services utilization.

(2) Paragraphs (a) and (b) of subdivision (1) of this subsection shall not be construed to prohibit a health carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the health carrier developed in compliance with sections 354.600 to 354.636.

(3) The provisions of sections 354.600 to 354.636 shall not require a health carrier, its intermediaries or the provider networks with which it contracts, to employ specific providers or types of providers, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

7. A health carrier shall file its selection standards for participating providers with the director. A health carrier shall also file any subsequent changes to its selection standards with the director. The selection standards shall be made available to licensed health care providers.

8. A health carrier shall notify a participating provider of the provider's responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

9. No contract between a health carrier and a provider for the delivery of health care service, entered into or renewed after August 28, 2001, shall require the mandatory use of a hospitalist. For purposes of this subsection, "hospitalist" means a physician who becomes a physician of record at a hospital for a patient of a participating provider and who may return the care of the patient to that participating provider at the end of hospitalization.

[9.**]** **10.** A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to an enrollee.

[10.**]** **11.** A health carrier shall not prohibit a participating provider from advocating in good faith on behalf of enrollees within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.

[11.**]** **12.** A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care but shall not disclose individual identities, or investigating the grievances or complaints of enrollees, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

[12.**]** **13.** The rights and responsibilities of a provider under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

[13.**]** **14.** A health carrier shall be responsible for ensuring that a participating provider furnishes covered benefits to all enrollees without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in a publicly financed program of health care service.

[14.**]** **15.** A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, co-payments or deductibles from enrollees pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify enrollees of their personal financial obligations for noncovered services.

[15.**]** **16.** A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that may jeopardize patient health or welfare.

[16.**]** **17.** A health carrier shall establish a mechanism by which a participating provider may determine in a timely manner whether a person is covered by the carrier.

[17.**]** **18.** A health carrier shall not discriminate between health care professionals when selecting such professionals for enrollment in the network or when referring enrollees for health care services to be provided by such health care professional who is acting within the scope of his professional license.

[18.**]** **19.** A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

[19.**]** **20.** A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or sections 354.600 to 354.636.

376.383. 1. For purposes of this section and section 376.384, the following terms

shall mean:

(1) "Claimant", any individual, corporation, association, partnership or other legal entity asserting a right to payment arising out of a contract or a contingency or loss covered under a health benefit plan as defined in section 376.1350;

(2) "Deny" or "denial", when the health carrier refuses to reimburse all or part of the claim;

(3) "Health carrier", health carrier as defined in section 376.1350, except that health carrier shall not include a workers' compensation carrier providing benefits to an employee pursuant to chapter 287, RSMo;

(4) "Health care provider", health care provider as defined in section 376.1350;

(5) "Health care services" health care services as defined in section 376.1350;

(6) "Processing days", number of days the health carrier has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a request for additional information;

(7) "Request for additional information", when the health carrier requests information from the claimant to determine if all or part of the claim will be reimbursed;

(8) "Suspends the claim", giving notice to the claimant specifying the reason the claim is not yet paid, including but not limited to grounds as listed in the contract between the claimant and the health carrier; and

(9) "Third party contractor", a third party contracted with the health carrier to receive or process claims for reimbursement of health care services.

2. Within ten working days after receipt of a claim by a health carrier or a third party contractor, a health carrier shall:

(1) Send an acknowledgment of the date of receipt; or

(2) Send notice of the status of the claim that includes a request for additional information.

If a health carrier pays the claim, subdivisions (1) and (2) shall not apply.

3. Within fifteen days after receipt of additional information by a health carrier or a third party contractor, a health carrier shall pay the claim or any undisputed part of the claim in accordance with this section or send a notice of receipt and status of the claim:

(1) That denies all or part of the claim and specifies each reason for denial; or

(2) That makes a final request for additional information.

4. Within fifteen days after the day on which the health carrier or a third party contractor receives the additional requested information in response to a final request for information, it shall pay the claim or any undisputed part of the claim or deny or suspend

the claim.

5. If the health carrier has not paid the claimant on or before the forty-fifth day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month. The interest shall be calculated based upon the unpaid balance of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest. A health carrier may combine interest payments and make payment once the aggregate amount reaches five dollars.

6. If a health carrier fails to pay, deny or suspend the claim within forty processing days, and has received, on or after the fortieth day, notice from the health care provider that such claim has not been paid, denied or suspended, the health carrier shall, in addition to monthly interest due, pay to the claimant per day an amount of fifty percent of the claim but not to exceed twenty dollars for failure to pay all or part of a claim or interest due thereon or deny or suspend as required by this section. Such penalty shall not accrue for more than thirty days unless the claimant provides a second written or electronic notice on or after the thirty days to the health carrier that the claim remains unpaid and that penalties are claimed to be due pursuant to this section. Penalties shall cease if the health carrier pays, denies or suspends the claim. Said penalty shall also cease to accrue on the day after a petition is filed in a court of competent jurisdiction to recover payment of said claim. Upon a finding by a court of competent jurisdiction that the health carrier failed to pay a claim, interest or penalty without reasonable cause, the court shall enter judgment for reasonable attorney fees for services necessary for recovery. Upon a finding that a provider filed suit without reasonable grounds to recover a claim, the court shall award the health carrier reasonable attorney fees necessary to the defense.

7. The department of insurance shall monitor suspensions and determine whether the health carrier acted reasonably.

8. If a health carrier or third party contractor has reasonable grounds to believe that a fraudulent claim is being made, the health carrier or third party contractor shall notify the department of insurance of the fraudulent claim pursuant to sections 375.991 to 375.994.

9. Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied.

10. Requests for additional information shall specify what additional information is necessary to process the claim for payment. Information requested shall be reasonable and pertain to the health carrier's determination of liability. The health carrier shall acknowledge receipt of the requested additional information to the claimant within five

working days or pay the claim.

376.384. 1. All health carriers shall:

(1) Permit nonparticipating health care providers to file a claim for reimbursement for a health care service provided in this state as defined in section 376.1350 for a period of up to one year from the date of service;

(2) Permit participating health care providers to file a claim for reimbursement for a health care service provided in this state for a period of up to six months from the date of service, unless the contract between the health carrier and health care provider specifies a different standard;

(3) Not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider;

(4) Issue within one working day a confirmation of receipt of an electronically filed claim.

2. On or after January 1, 2003, all claims for reimbursement for a health care service provided in this shall be submitted in an electronic format consistent with federal administrative simplification standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996. Any claim submitted by a health care provider after January 1, 2003, in a non-electronic format shall not be subject to the provisions of section 376.383. Any health carrier shall provide readily accessible electronic filing after this date to health care providers.

3. On or after January 1, 2002, the director of the department of insurance shall monitor health carrier compliance with the provisions of sections 376.383 and 376.384. Examinations, which may be based upon statistical samplings, to determine compliance may be conducted by the department or the director may contract with a qualified private entity. Compliance shall be defined as properly processing and paying ninety-five percent of all claims received in a given calendar year in accordance with the provisions of sections 376.383 and 376.384. The director may assess an administrative penalty in addition to the penalties outlined in section 376.383 of up to twenty-five dollars per claim for the percentage of claims found to be in noncompliance, but not to exceed an annual aggregate penalty of two hundred fifty thousand dollars, for any health carrier deemed to be not it compliance with sections 376.383 and 376.384. Any penalty assessed pursuant to this subsection shall be assessed in addition to penalties provided for pursuant to sections 375.1012 and 375.942.

4. If the director finds that health carriers are failing to make interest payments to health care professionals authorized by section 376.383, the director is authorized to order

such health carriers to remit such interest payments. The director is also authorized to assess a monetary penalty, payable to the state of Missouri, in a sum not to exceed twenty-five percent of the unpaid interest payment against health carriers.

5. A health carrier may request a waiver of the requirements of sections 376.383 and 376.384 if the basis for the request is an act of God or other good cause as determined by the director.

6. The director shall develop a method by which health care providers may submit complaints to the department identifying violations of sections 376.383 and 376.384 by a health carrier. The director shall consider such complaints when determining whether to examine a health carrier's compliance. Prior to filing a complaint with the department, health care providers who believe that a health carrier has not paid a claim in accordance with section 376.383 and this section shall first contact the health carrier to determine the status of the claim to ensure that sufficient documentation supporting the claim has been provided and to determine whether the claim is considered to be complete. Complaints to the department regarding the payment of claims by a health carrier should contain information such as:

(1) The health care provider's name, address, and day-time phone number;

(2) The health carrier's name;

(3) The dates of service and the dates the claims were filed with the health carrier;

(4) Relevant correspondence between the health care provider and the health carrier, including requests from the health carrier for additional information; and

(5) Additional information which the health care provider believes would be of assistance in the department's review.

7. On or after January 1, 2003, all claims submitted electronically for reimbursement for a health care service provided in this state shall be submitted in a uniform format utilizing standard medical code sets. The uniform format and the standard medical code sets shall be promulgated by the department of insurance through rules consistent with but no more stringent than the federal administrative simplification standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996.

8. The department shall have authority to promulgate rules for the implementation of section 376.383 and this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and if applicable, sections 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly

pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2001, shall be invalid and void.

376.406. 1. All **[**individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, and all self-insured group health benefit plans, of any type or description,**]** **health benefit plans** which provide coverage for a family member of **[**the insured or subscriber**]** **an enrollee** shall, as to such family member's coverage, also provide that the health **[**insurance**]** benefits applicable for children shall be payable with respect to a newly born child of the **[**insured or subscriber**] enrollee** from the moment of birth.

2. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

3. If payment of a specific premium or subscription fee is required to provide coverage for a child, the **[**policy or contract**] health benefit plan** may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the **[**insurer or nonprofit service or indemnity corporation**] health carrier** within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one day period. **If an application or other form of enrollment is required in order to continue coverage beyond the thirty-one-day period after the date of birth and the enrollee has notified the health carrier of the birth, either orally or in writing, the health carrier shall, upon notification, provide the enrollee with all forms and instructions necessary to enroll the newly born child and shall allow the enrollee an additional ten days from the date the forms and instructions are provided in which to enroll the newly born child.**

4. The requirements of this section shall apply to all **[**insurance policies and subscriber contracts**] health benefit plans** delivered or issued for delivery in this state **[**more than one hundred twenty days after August 13, 1974**] on or after August 28, 2001**.

5. For the purposes of this section, any review, renewal, extension, or continuation of any **[**plan, policy, or contract**] health benefit plan** or of any of the terms, premiums, or subscriptions of the **[**plan, policy, or contract**] health benefit plan** shall constitute a new delivery or issuance for delivery of the **[**plan, policy or contract**] health benefit plan**.

6. As used in this section, the terms "health benefit plan", "health carrier", and "enrollee" shall have the same meaning as defined in section 376.1350.

[376.383. 1. To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section shall apply to any health insurer as defined in section 376.806, any nonprofit health service plan and any health maintenance organization.

2. Within forty-five days after receipt of a claim for reimbursement from a person entitled to reimbursement, a health insurer, nonprofit health service plan or health maintenance organization shall pay the claim in accordance with this section or send a notice of receipt and status of the claim that states:

(1) That the insurer, nonprofit health service plan or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal; or

(2) That additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary.

3. If an insurer, nonprofit health service plan or health maintenance organization fails to comply with subsection 2 of this section, the insurer, nonprofit health service plan or health maintenance organization shall pay interest on the amount of the claim that remains unpaid forty- five days after the claim is filed at the monthly rate of one percent. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest.

4. Within ten days after the day on which all additional information is received by an insurer, nonprofit health service plan or health maintenance organization, it shall pay the claim in accordance with this section or send a written notice that:

(1) States refusal to reimburse the claim or any part of the claim; and

(2) Specifies each reason for denial.

An insurer, nonprofit health service plan or health maintenance organization that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the monthly rate of one percent.

5. A provider who is paid interest under this section shall pay the proportionate amount of said interest to the enrollee or insured to the extent and for the time period that the enrollee or insured had paid for the services and for which reimbursement was due to the insured or enrollee.

6. This section shall become effective April 1, 1999.**]**

Section 1. 1. A completed application for medical assistance for services described in section 208.152 shall be approved or denied within thirty days from submission to the division of family services or its successor.

2. The division of medical services shall remit to a licensed nursing home operator the medicaid payment for a newly admitted medicaid resident in a licensed long term care facility within forty-five days of the resident's date of admission.

Section 2. No insurer or its agent or representative shall require any applicant or policyholder to divulge if any insurer has denied any claim of that applicant or policyholder.

Section B. The repeal and reenactment of section 376.383 and the enactment of section 376.384 shall become effective January 1, 2002.