FIRST REGULAR SESSION

HOUSE BILL NO. 831

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES MOLENDORP (Sponsor) AND TILLEY (Co-sponsor).

2047L.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 354.618, RSMo, and to enact in lieu thereof two new sections relating to community-based health maintenance organizations.

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

Section A. Section 354.618, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 354.618 and 354.619, to read as follows:

354.618. 1. A health carrier shall be required to offer as an additional health plan, an open referral health plan whenever it markets a gatekeeper group plan as an exclusive or full replacement health plan offering to a group contract holder:

(1) In the case of group health plans offered to employers of fifty or fewer employees, the decision to accept or reject the additional open referral plan offering shall be made by the group contract holder. For health plans marketed to employers of over fifty employees, the decision to accept or reject shall be made by the employee;

(2) Contracts currently in existence shall offer the additional open referral health plan at the next annual renewal after August 28, 1997; however, multiyear group contracts need not comply until the expiration of their current multiyear term unless the group contract holder elects to comply before that time;

(3) If an employer provides more than one health plan to its employees and at least one is an open referral plan, then all health benefit plans offered by such employer shall be exempt from the requirements of this section.

2. For the purposes of this act, the following terms shall mean:

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

(1) "Open referral plan", a plan in which the enrollee is allowed to obtain treatment for covered benefits without a referral from a primary care physician from any person licensed to provide such treatment;

(2) "Gatekeeper group plan", a plan in which the enrollee is required to obtain a referral from a primary care professional in order to access specialty care.

3. Any health benefit plan provided pursuant to the Medicaid program shall be exempt from the requirements of this section.

4. A health carrier shall have a procedure by which a female enrollee may seek the health care services of an obstetrician/gynecologist at least once a year without first obtaining prior approval from the enrollee's primary care provider if the benefits are covered under the enrollee's health benefit plan, and the obstetrician/gynecologist is a member of the health carrier's network. In no event shall a health carrier be required to permit an enrollee to have health care services delivered by a nonparticipating obstetrician/gynecologist. An obstetrician/gynecologist who delivers health care services directly to an enrollee shall report such visit and health care services provided to the enrollee's primary care provider. A health carrier may require an enrollee to obtain a referral from the primary care physician, if such enrollee requires more than one annual visit with an obstetrician/gynecologist.

5. **[**Except for good cause, a health carrier shall be prohibited either directly, or indirectly through intermediaries, from discriminating between eye care providers when selecting among providers of health services for enrollment in the network and when referring enrollees for health services provided within the scope of those professional licenses and when reimbursing amounts for covered services among persons duly licensed to provide such services. For the purposes of this section, an eye care provider may be either an optometrist licensed pursuant to chapter 336, RSMo, or a physician who specializes in opthamologic medicine, licensed pursuant to chapter 334, RSMo.

6.**]** Nothing contained in this section shall be construed as to require a health carrier to pay for health care services not provided for in the terms of a health benefit plan.

[7.**] 6.** Any health carrier, which is sponsored by a federally qualified health center and is presently in existence and which has been in existence for less than three years shall be exempt from this section for a period not to exceed two years from August 28, 1997.

[8.**] 7.** A health carrier shall not be required to offer the direct access rider for a group contract holder's health benefit plan if the health benefit plan is being provided pursuant to the terms of a collective bargaining agreement with a labor union, in accordance with federal law and the labor union has declined such option on behalf of its members.

[9.**]** **8.** Nothing in this act shall be construed to preempt the employer's right to select the health care provider pursuant to section 287.140, RSMo, in a case where an employee incurs a work-related injury covered by the provisions of chapter 287, RSMo.

[10.**]** **9.** Nothing contained in this act shall apply to certified managed care organizations while providing medical treatment to injured employees entitled to receive health benefits under chapter 287, RSMo, pursuant to contractual arrangements with employers, or their insurers, under section 287.135, RSMo.

354.619. 1. Except for good cause, a health carrier shall be prohibited, either directly or indirectly through intermediaries, from discriminating between eye care providers when selecting among providers of health services for enrollment in the network and when referring enrollees for health services provided within the scope of those professional licenses and when reimbursing amounts for covered services among persons licensed to provide such services. For the purposes of this section, an eye care provider may be either an optometrist licensed under chapter 336, RSMo, or a physician who specializes in ophthalmologic medicine, licensed under chapter 334, RSMo.

2. A health carrier shall not, directly or indirectly through intermediaries, refuse to select an eye care provider for the network solely on the grounds that:

(1) Not all eye care providers in a group practice agree to participate in the health carrier's provider network; or

(2) The provider is not a retailer of frames and corrective lenses.

3. If services are being provided by an optometrist in connection to a treatment plan for corrective surgery, a health carrier shall not, directly or indirectly through intermediaries, refuse to select an eye care provider for the network, refuse to refer an enrollee for health services provided within the scope of an eye care provider's license, or discriminate in the level of reimbursement for covered services among eye care providers licensed to provide such services.

4. A health carrier shall not require a licensed optometrist who provides basic medical eye care to participate solely through an intermediary if such health carrier permits ophthalmologists to contract directly with the health carrier.

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