SECOND REGULAR SESSION

HOUSE BILL NO. 2205

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE BURLISON.

5152L.02I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 354.442 and 376.1450, RSMo, and to enact in lieu thereof two new sections relating to documents and materials for health insurance enrollees.

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

Section A. Sections 354.442 and 376.1450, RSMo, are repealed and two new sections
2 enacted in lieu thereof, to be known as sections 354.442 and 376.1450, to read as follows:
354.442. 1. Each enrollee, and upon request each prospective enrollee prior to
2 enrollment, shall be supplied with written disclosure information. In the event of any
3 inconsistency between any separate written disclosure statement and the enrollee contract or
4 evidence of coverage, the terms of the enrollee contract or evidence of coverage shall be
5 controlling. The information to be disclosed in writing shall include at a minimum the
6 following:
7 (1) A description of coverage provisions, health care benefits, benefit maximums,
8 including benefit limitations;
9 (2) A description of any exclusions of coverage, including the definition of medical
10 necessity used in determining whether benefits will be covered;
11 (3) A description of all prior authorization or other requirements for treatments and
12 services;
13 (4) A description of utilization review policies and procedures used by the health
14 maintenance organization, including:
15 (a) The circumstances under which utilization review shall be undertaken;
16 (b) The toll-free telephone number of the utilization review agent;

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.

17 (c) The time frames under which utilization review decisions shall be made for
18 prospective, retrospective and concurrent decisions;
19 (d) The right to reconsideration;
20 (e) The right to an appeal, including the expedited and standard appeals processes and
21 the time frames for such appeals;
22 (f) The right to designate a representative;
23 (g) A notice that all denials of claims shall be made by qualified clinical personnel and
24 that all notices of denial shall include information about the basis of the decision; and
25 (h) Further appeal rights, if any;
26 (5) An explanation of an enrollee's financial responsibility for payment of premiums,
27 coinsurance, co-payments, deductibles and any other charge, annual limits on an enrollee's
28 financial responsibility, caps on payments for covered services and financial responsibility for
29 noncovered health care procedures, treatments or services provided within the health
30 maintenance organization;
31 (6) An explanation of an enrollee's financial responsibility for payment when services
32 are provided by a health care provider who is not part of the health maintenance organization's
33 network or by any provider without required authorization, or when a procedure, treatment or
34 service is not a covered health care benefit;
35 (7) A description of the grievance procedures to be used to resolve disputes between a
36 health maintenance organization and an enrollee, including:
37 (a) The right to file a grievance regarding any dispute between an enrollee and a health
38 maintenance organization;
39 (b) The right to file a grievance when the dispute is about referrals or covered benefits;
40 (c) The toll-free telephone number which enrollees may use to file a grievance;
41 (d) The department of insurance, financial institutions and professional registration's
42 toll-free consumer complaint hot line number;
43 (e) The time frames and circumstances for expedited and standard grievances;
44 (f) The right to appeal a grievance determination and the procedures for filing such an
45 appeal;
46 (g) The time frames and circumstances for expedited and standard appeals;
47 (h) The right to designate a representative;
48 (i) A notice that all disputes involving clinical decisions shall be made by qualified
49 clinical personnel; and
50 (j) All notices of determination shall include information about the basis of the decision
51 and further appeal rights, if any;

52 (8) A description of a procedure for providing care and coverage twenty-four hours a
53 day, seven days a week, for emergency services. Such description shall include the definition
54 of emergency services and emergency medical condition, notice that emergency services are not
55 subject to prior approval, and shall describe the enrollee's financial and other responsibilities
56 regarding obtaining such services, including when such services are received outside the health
57 maintenance organization's service area;
58 (9) A description of procedures for enrollees to select and access the health maintenance
59 organization's primary and specialty care providers, including notice of how to determine
60 whether a participating provider is accepting new patients;
61 (10) A description of the procedures for changing primary and specialty care providers
62 within the health maintenance organization;
63 (11) Notice that an enrollee may obtain a referral for covered services to a health care
64 provider outside of the health maintenance organization's network or panel when the health
65 maintenance organization does not have a health care provider with appropriate training and
66 experience in the network or panel to meet the particular health care needs of the enrollee and
67 the procedure by which the enrollee may obtain such referral;
68 (12) A description of the mechanisms by which enrollees may participate in the
69 development of the policies of the health maintenance organization;
70 (13) Notice of all appropriate mailing addresses and telephone numbers to be utilized
71 by enrollees seeking information or authorization;
72 (14) **[**A listing**]** **Listings** by specialty, which may be in **[**a**]** separate **[**document that is**]**
73 **documents that are** updated annually, of the names, addresses and telephone numbers of all
74 participating providers, including facilities, and in addition in the case of physicians, board
75 certification; and
76 (15) The director of the department of insurance, financial institutions and professional
77 registration shall develop a standard credentialing form which shall be used by all health carriers
78 when credentialing health care professionals in a managed care plan. If the health carrier
79 demonstrates a need for additional information, the director of the department of insurance,
80 financial institutions and professional registration may approve a supplement to the standard
81 credentialing form. All forms and supplements shall meet all requirements as defined by the
82 National Committee of Quality Assurance.
83 2. Each health maintenance organization shall, upon request of an enrollee or prospective
84 enrollee, provide the following:
85 (1) A list of the names, business addresses and official positions of the membership of
86 the board of directors, officers, controlling persons, owners or partners of the health maintenance
87 organization;

88 (2) A copy of the most recent annual certified financial statement of the health
89 maintenance organization, including a balance sheet and summary of receipts and disbursements
90 prepared by a certified public accountant;
91 (3) A copy of the most recent individual, direct pay enrollee contracts;
92 (4) Information relating to consumer complaints compiled annually by the department
93 of insurance, financial institutions and professional registration;
94 (5) The procedures for protecting the confidentiality of medical records and other
95 enrollee information;
96 (6) An opportunity to inspect drug formularies used by such health maintenance
97 organization and any financial interest in a pharmacy provider utilized by such organization. The
98 health maintenance organization shall also disclose the process by which an enrollee or his
99 representative may seek to have an excluded drug covered as a benefit;
100 (7) A written description of the organizational arrangements and ongoing procedures of
101 the health maintenance organization's quality assurance program;
102 (8) A description of the procedures followed by the health maintenance organization in
103 making decisions about the experimental or investigational nature of individual drugs, medical
104 devices or treatments in clinical trials;
105 (9) Individual health practitioner affiliations with participating hospitals, if any;
106 (10) Upon written request, written clinical review criteria relating to conditions or
107 diseases and, where appropriate, other clinical information which the organization may consider
108 in its utilization review. The health maintenance organization may include with the information
109 a description of how such information will be used in the utilization review process;
110 (11) The written application procedures and minimum qualification requirements for
111 health care providers to be considered by the health maintenance organization;
112 (12) A description of the procedures followed by the health maintenance organization
113 in making decisions about which drugs to include in the health maintenance organization's drug
114 formulary.
115 3. Nothing in this section shall prevent a health maintenance organization from changing
116 or updating the materials that are made available to enrollees.
117 **4. The information to be provided under subsections 1 and 2 of this section may be**
118 **provided online unless a paper copy is requested by the enrollee. A request by the enrollee**
119 **may include written, oral or electronic means. Such requested paper copy shall be**
120 **provided to the enrollee within fifteen business days.**

376.1450. An enrollee, as defined in section 376.1350, may **[**waive his or her right to**]**
2 receive documents and materials from a managed care entity in printed **or electronic** form so
3 long as such documents and materials are readily accessible **[**electronically through the entity's

4 Internet site. An enrollee may revoke such waiver at any time by notifying the managed care
5 entity by phone or in writing or annually. Any enrollee who does not execute such a waiver and
6 prospective enrollees shall have documents and materials from the managed care entity provided]
7 in printed form **upon request. A request by the enrollee may include written, oral, or**
8 **electronic means. Such requested printed form shall be provided to the enrollee within**
9 **fifteen business days**. For purposes of this section, "managed care entity" includes, but is not
10 limited to, a health maintenance organization, preferred provider organization, point of service
11 organization and any other managed health care delivery entity of any type or description.

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