
**Rules of
Department of Insurance
Division 400—Life, Annuities and Health
Chapter 7—Health Maintenance Organizations**

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**Title 20—DEPARTMENT OF
INSURANCE**

**Division 400—Life, Annuities and Health
Chapter 7—Health Maintenance
Organizations**

**20 CSR 400-7.010 Forms Which Must be
Approved Prior to Use**

PURPOSE: This rule describes the forms which must be filed by a health maintenance organization with the Department of Insurance for approval prior to use. This rule is promulgated pursuant to sections 354.405 and 354.485, RSMo.

(1) The following forms shall not be delivered or issued for delivery in this state until they have been submitted to the Missouri Department of Insurance and approved by the director:

- (A) Group and individual contracts;
- (B) Evidence of coverage to be issued to the enrollees;
- (C) Application forms;
- (D) Enrollment forms;
- (E) Riders;
- (F) Amendments;
- (G) Endorsements; and
- (H) Any other forms which are intended to become part of a contract which is provided to an enrollee or group subscriber.

(2) Each filing shall be made in accordance with the procedures outlined in 20 CSR 400-8.200.

AUTHORITY: sections 354.405 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.075. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority 1983.*

**20 CSR 400-7.020 Changes to Documents
Submitted to Obtain Original Certificate
of Authority**

PURPOSE: This rule sets forth the documents which must be submitted to the Department of Insurance prior to any changes becoming effective. This rule is promulgated pursuant to sections 354.405, 354.410, 354.425 and 354.485, RSMo.

(1) Every health maintenance organization (HMO) shall file with the director notice of its intention to modify or change the documents and mechanisms approved in conjunction with the HMO's application for a certificate of authority pursuant to sections 354.400—354.550, RSMo. This notice shall

be filed prior to the actual modification. These documents and mechanisms include, but are not limited to:

- (A) Articles of incorporation, articles of association, partnership agreement or trust agreement;
- (B) Bylaws, rules or similar documents regulating the HMO's internal affairs;
- (C) Grievance procedure and complaint mechanisms;
- (D) Enrollee participation mechanism;
- (E) Reinsurance contracts; and
- (F) Bonds (surety and fidelity).

(2) The documents and mechanisms, as modified, shall be promptly filed with the director for approval. If the modification is not disapproved by the director within thirty (30) days after filing, the modification shall be deemed approved.

AUTHORITY: sections 354.405, 354.410, 354.425 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.080. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority 1983.*

**20 CSR 400-7.030 Mandatory Provisions—
All Contracts**

PURPOSE: This rule sets forth the provisions which must be present in an evidence of coverage. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) All group and individual contracts and all evidences of coverage must contain in substance the following provisions, or provisions which in the opinion of the director of insurance are more favorable to the enrollee or at least as favorable to the enrollee and more favorable to the contract holder: name, address and telephone number of the administrative offices of the health maintenance organization (HMO) must appear on the face page; the face page is the first page that contains any written material; and if in booklet form, the first page inside the cover is the face page.

(2) Benefits. A description of all health care services available to an enrollee under the health care plan, including any copayments or other charges for which the member may be responsible.

(3) Cancellation. A statement that the HMO must give the group contract holder, in the case of group coverage, or the enrollee, in the case of individual coverage, at least thirty-one

(31) days' prior notice of any cancellation or termination except termination for nonpayment of premium. In the case of group coverage, the HMO may not terminate the contract prior to the first anniversary date except for nonpayment of the required premium or the failure to meet continued underwriting standards.

(4) Claim Filing Procedure. A provision setting forth the procedure for filing claims, including:

(A) How, when and where to obtain claim forms, if required; and

(B) The requirements for providing proper notice of claim and proof of loss. Failure to furnish the notice or proof within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to give notice or proof within this time.

(5) Definitions. A provision defining any words in the evidence of coverage which have other than the usual meaning.

(6) Effective Date. A statement of the effective date requirements for various classes of enrollees.

(7) Eligibility. A statement of the eligibility requirements for coverage including:

(A) The condition under which dependent enrollees may be added to those originally covered;

(B) Any limiting age for enrollees and dependents, including effects of Medicare eligibility; and

(C) A clear statement regarding the coverage of newborn children. All evidences of coverage which provide coverage for a family member of the enrollee, as to this family member's coverage, also shall provide that the benefits applicable for children also shall be applicable with respect to a newly born child of the enrollee from the moment of birth. 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. The HMO may require that the enrollee notify the HMO during the initial thirty-one (31) days after the birth of the child and pay any additional premium required to provide coverage for the newborn child from the date of birth.

(8) Emergency Services. A description of how to obtain services in an emergency situation, including:

(A) Any requirements that the HMO be contacted before the enrollee obtains care; and



(B) What to do in case of a life-threatening emergency.

(9) Out-of-Area Benefits and Services. The contract and evidence of coverage shall contain a specific description of benefits and services available out of the service area. Medically necessary emergency benefits must be available when the enrollee is temporarily outside the service area and—

(A) Medically necessary health services are immediately required;

(B) The condition for which the services are required could not have been foreseen;

(C) The enrollee's medical condition does not permit his/her return to the service area for treatment;

(D) The reason for being outside the service area must be for some purpose other than the receipt of treatment for a medically-related condition;

(E) The HMO may require notification from or on behalf of the enrollee as soon as possible; and

(F) Services received by the enrollee outside the service area will be covered until the enrollee's medical condition permits travel or transport to the HMO's service area.

(10) Entire Contract, Amendments. A provision stating that the contract and any attachments constitute the entire contract between the parties and that, to be valid, any change in the contract must be approved by an officer of the HMO and attached to the affected contract and that no agent or representative has the authority to change the contract or waive any of the provisions.

(11) Exclusions and Limitations. A provision setting forth any exclusions and limitations on health care services.

(12) Time Limit on Certain Defenses. A provision that, in the absence of fraud, all statements made by an enrollee are considered representations and not warranties and that no statement voids the coverage or reduces the benefits after the coverage has been in force for two (2) years from its effective date, unless the statement was material to the risk assumed and contained in a written application. A copy of the written application or enrollment form must have been furnished to the enrollee if the terms of the application or enrollment form are to be applied.

(13) Schedule of Rates. A provision that discloses the HMO's right to change the rates charged and indicates the amount of prior notice which must be given.

(14) Service Area. A map or clear description of the service area indicating major primary and emergency care delivery sites.

(15) Termination Due to Attaining Limiting Age.

(A) Medicare. A provision describing the effect of becoming eligible for Medicare on the part of an enrollee or dependent.

(B) Handicapped Child. A provision that a child's attainment of a limiting age does not operate to terminate coverage of the child while that child is incapable of self-sustaining employment due to mental or physical handicap and chiefly dependent upon the enrollee for support and maintenance. The enrollee may be required to furnish proof of incapacity and dependency within thirty-one (31) days before the child's attainment of the limiting age and subsequently, as required, but not more frequently than annually following the child's attainment of the limiting age.

(16) Where to Obtain Services. A statement explaining where and in what manner information is available as to how services may be obtained.

(17) Every HMO that has a plan which will affect the choice of physician, hospital or other health care provider, such as by refusing to cover services rendered by a provider not affiliated with the HMO, shall set forth conspicuously the following statement, or other wording which has been approved by the director to the same effect, on the following materials when given to current and prospective enrollees: certificates and evidences of coverage, member handbooks, provider directories and any materials which make a direct offer to an individual prospective enrollee to become a member of the HMO.

NOTICE

THIS HMO MAY HAVE RESTRICTIONS REGARDING WHICH PHYSICIANS OR OTHER HEALTH CARE PROVIDERS AN HMO MEMBER MAY USE. PLEASE CONSULT YOUR MEMBER HANDBOOK OR PROVIDER DIRECTORY FOR MORE DETAILS. IF YOU HAVE ANY ADDITIONAL QUESTIONS, PLEASE WRITE OR CALL US AT:

(HMO's Name)

(HMO's Address)

(HMO's Telephone Number)

(A) The HMO shall not be required to place such a statement in materials that con-

stitute or represent supplemental benefit riders, copayment schedules or marketing or promotional material including, but not limited to, posters or print or media advertisements, which are not directed to specific individual enrollees but which may be directed toward a group(s) of enrollees.

(B) Every HMO shall include such a statement at the time promotional and descriptive materials, disclosure forms and certificates and evidences of coverage are issued or revised for distribution, but in no case later than the effective date of section (17) of this rule (January 1, 1994).

AUTHORITY: sections 354.430 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.090. Original rule filed Nov. 2, 1987, effective April 11, 1988. Amended: Filed Nov. 3, 1992, effective Jan. 1, 1994.*

**Original authority 1983.*

20 CSR 400-7.040 Additional Mandatory Provisions—Group Contracts and Evidences of Coverage

PURPOSE: This rule sets forth provisions which must be included in group contracts and evidences of coverage in addition to the provisions set forth in 20 CSR 400-7.030. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) Group contracts and evidences of coverage must contain in substance the following provision(s) which, in the opinion of the director of insurance, are more favorable to the enrollee or at least as favorable to the enrollee and more favorable to the contract holder in addition to those set out in 20 CSR 400-7.030.

(2) Evidence of Coverage. Provisions that the group contract holder must be provided with evidence of coverage to be delivered to each enrollee, that the evidence of coverage is a part of the group contract as if fully incorporated in the contract; and that any direct conflict between the group contract and the evidence of coverage will be resolved according to the terms which are most favorable to the enrollee. Note: This section does not apply if the same form is used for both the group contract and the evidence of coverage.

(3) New Employees. A provision specifying the conditions under which new enrollees may be added to those originally covered, including the terms under which coverage will be effective.

(4) Grace Period. A provision for a grace period of at least thirty-one (31) days for the payment of any premium falling due after the first premium, during which time the coverage remains in effect. Coverage may be terminated at the end of the grace period and, if services are rendered during the grace period, the group will be responsible for either the premium due or the value of services received.

AUTHORITY: sections 354.430 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.110. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority 1983.*

20 CSR 400-7.050 Additional Mandatory Provisions—Individual Contracts and Evidences of Coverage

PURPOSE: This rule sets forth provisions which must be included in individual contracts and evidences of coverage in addition to the provisions set forth in 20 CSR 400-7.030. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) Individual contracts and evidences of coverage must contain in substance the following provision(s) which, in the opinion of the director of insurance, are at least as or more favorable to the enrollee, in addition to those set out in 20 CSR 400-7.030.

(2) Reinstatement. A provision that clearly sets forth the requirements for reinstatement and discloses how reinstatement changes or affects the rights and coverages originally provided. New evidence on insurability may be required.

(3) Ten (10) Days to Examine Agreement. A provision stating that the enrollee to whom the evidence of coverage is issued shall be permitted to return the evidence of coverage within ten (10) days of receiving it and have the premium paid refunded to them if, after examination of the agreement, the enrollee is not satisfied with it for any reason. If the enrollee, pursuant to provision, returns the evidence of coverage to the issuing health maintenance organization (HMO) or to the agent or representative through whom it was purchased, it is considered void from the beginning and the parties are in the same position as if no evidence of coverage had been issued. If services are rendered or claims paid by the HMO during the ten (10) days, the person shall not be permitted to

return the contract and receive a refund of the premium paid.

(4) Original Premium. The original premium for coverage must be stated in the evidence of coverage or in the application.

(5) Grace Period. A provision for a grace period of at least ten (10) days, for payment of any premium falling due after the first premium, during which time the coverage remains in effect. If payment is not received within ten (10) days, coverage may be cancelled after the tenth day. The terminated enrollee will be responsible for the cost of services received during the grace period if this requirement is disclosed in the evidence of coverage.

AUTHORITY: sections 354.430 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.100. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority 1983.*

20 CSR 400-7.060 Integration With Other Benefits

PURPOSE: This rule provides that a health maintenance organization integration provision must be consistent with the Coordination of Benefit Provisions in Group Health Plans set forth in 20 CSR 400-2.030. This rule is promulgated pursuant to section 354.485, RSMo.

Those provisions of a health maintenance organization (HMO) contract which are designed to coordinate with the benefits of other health plans must be consistent with the corresponding provisions of 20 CSR 400-2.030, Coordination of Benefit Provisions in Group Health Plans.

AUTHORITY: section 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.130 Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority 1983.*

20 CSR 400-7.070 Bonding Requirements

PURPOSE: This rule sets forth the health maintenance organization bond requirements and when those requirements will be deemed satisfied. This rule is promulgated pursuant to sections 354.425 and 354.485, RSMo.

(1) The requirement of section 354.425, RSMo that every health maintenance organi-

zation (HMO) shall maintain in force a surety bond on any director, officer or partner who receives, collects, disburses or invests funds in connection with the activities of the HMO will be deemed to be satisfied by a fidelity bond or contract of equal purpose. This bond or contract shall—

(A) Be in an amount of not less than one hundred thousand dollars (\$100,000) or other sum as may be prescribed by the director;

(B) Be written with at least a one (1)-year discovery period. If written with less than a three (3)-year discovery period, the bond or contract shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of ninety (90) days after written notice of the cancellation or termination has been filed with the director of the Department of Insurance, unless an earlier date is approved by the director; and

(C) Specify on the declaration page of the bond or contract the length of the discovery period and, if less than three (3) years, that the bond or contract complies with the ninety (90)-day notification of cancellation or termination provision of section 354.425, RSMo.

AUTHORITY: sections 354.425 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.140. Original rule filed Nov. 2, 1987, effective April 11, 1988.*

**Original authority 1983.*

20 CSR 400-7.080 Enrollee Protection Provisions

PURPOSE: This rule sets forth enrollee protection provisions. This rule is promulgated pursuant to section 354.485, RSMo.

(1) Providers who provide health care services to health maintenance organization (HMO)-covered enrollees pursuant to a provider contract between themselves and the HMO, under no circumstances (including, but not limited to, nonpayment by an HMO for medical services rendered to an enrollee by a provider, insolvency of an HMO or an HMO's breach of any term or condition of its agreement with a provider), shall bill, charge, collect a deposit, seek compensation, remuneration or reimbursement from or have any recourse against an enrollee or person acting on behalf of an enrollee for fees, charges or expenses relating to medical services which the HMO is obligated to provide and pay for under the terms of the enrollee's subscriber agreement with the HMO.



(2) In order to ensure compliance with this provision, no contract between an HMO and provider will be valid or enforceable by the provider unless the contract specifically establishes an independent contractor relationship between the HMO and the provider and further provides that under no circumstances (including, but not limited to, those sets of circumstances previously described) shall the provider bill, charge or in any way seek to hold an enrollee legally liable for the payment of any fees which are the legal obligation of the HMO as provided in this rule.

(3) The contract must further provide that the provision referred to in this rule will survive the termination of the provider's agreement with the HMO regardless of the cause of the termination and that the terms are applicable to, and binding upon, all individuals with whom a provider may subcontract to provide services to HMO enrollees. Nothing in this provision, however, shall in any way affect or limit a provider's right or obligation to collect from enrollees copayments, deductibles or fees assessed for noncovered services in accordance with the agreement governing the enrollee's enrollment with the HMO.

*AUTHORITY: section 354.485, RSMo 1986. * This rule was previously filed as 4 CSR 190-15.160. Original rule filed Nov. 2, 1987, effective April 12, 1988.*

**Original authority 1983.*

20 CSR 400-7.090 Service Area Expansion

PURPOSE: This rule sets forth the information to be provided to the director by a health maintenance organization seeking to expand its service area. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

(1) For a contiguous service area expansion request to be approved, the health maintenance organization (HMO) must provide the director with the following information in support of the request:

(A) If prior action of the HMO's board is required, minutes of the board meeting at which expansion was authorized and any related amendments to the basic organization document or bylaws;

(B) A map of the new service area showing locations of primary care physicians, hospitals and emergency care facilities;

(C) Any *pro forma* contracts or agreements with physicians and other providers in the new area; and

(D) A list of all physicians and other providers who have agreed to provide services in the new area.

(2) If the new area is not contiguous with the previously approved area, the following additional information must be provided:

(A) A brief narrative description of the administrative arrangements and other pertinent information;

(B) Biographical data sheets for the management staff assigned to the new area;

(C) Enrollee participation plan for the new area;

(D) Marketing information about the new area, including demographic material, enrollment projections for the period from the beginning of operations until operations in the new service area have produced a net income for twelve (12) consecutive months and proposed advertising and sales materials;

(E) Evidence of coverage to be used in the new area;

(F) Rates to be charged and appropriate actuarial certifications;

(G) Copies of leases, loans and contracts to be used in the proposed new area; and

(H) Sources of financing and financial projections for the period from the beginning of operations until operations in the new area will have produced a net income for twelve (12) consecutive months.

(3) The HMO shall provide other information as the director may consider necessary to adequately describe the proposal.

*AUTHORITY: section 354.485, RSMo 1986. * This rule was previously filed as 4 CSR 190-15.170. Original rule filed Nov. 2, 1987, effective April 12, 1988.*

**Original authority 1983.*

20 CSR 400-7.095 Provider Network Adequacy Standards

PURPOSE: This rule sets forth standards to ensure that health maintenance organizations 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.

(1) Definitions.

(A) Categories of counties.

1. Urban access counties—Counties with a population of two hundred thousand (200,000) or more persons.

2. Basic access counties—Counties with a population between fifty thousand (50,000) persons and one hundred ninety-nine thou-

sand nine hundred ninety-nine (199,999) persons.

3. Rural access counties—Counties with a population of fewer than fifty thousand (50,000) persons.

4. Population figures shall be based on census data as reported in the latest edition of the *Official Manual of the State of Missouri*.

(B) Closed practice provider—A health care provider who does not accept new or additional patients from the health maintenance organization (HMO) that is reporting the provider as part of the HMO's network.

(C) Hospitals.

1. Basic—Hospitals with central services, dietary services, emergency services, medical records, nursing services, pathology and medical laboratory services, pharmaceutical services, radiology services, social work services and an inpatient care unit.

2. Secondary—Hospitals with all of the facilities listed under "Basic," plus one (1) or more operating rooms, obstetrics unit, and intensive care unit; and

3. Tertiary—Hospitals with all of the facilities listed under "Basic" and "Secondary," plus Level I trauma unit, neonatal intensive care unit, perinatology unit, comprehensive cancer center, and facilities and personnel for providing cardiac catheterization, cardiac surgery, and pediatric subspecialty care.

(D) Network—The group of participating providers providing services to a managed care plan or pursuant to a health benefit plan established by an HMO.

(E) Pharmacy—Any pharmacy, drug, chemical store, or apothecary shop, conducted for the purpose of compounding, and dispensing and retailing of any drug, medicine, chemical, or poison when used in the compounding of a physician's prescription, and possessing a valid and current permit issued by the state of Missouri Board of Pharmacy.

(F) Primary care provider (PCP)—A participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to an enrollee, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the enrollee.

(G) Specialist—A licensed health care provider whose area of specialization is in an area other than general medicine, family medicine, general internal medicine, or general pediatrics. A physician whose area of specialization is obstetrics and/or gynecology may be either a PCP or a specialist within the meaning of this rule.

(2) Network Adequacy Standards—Health maintenance organizations shall file with the



director of the Department of Insurance an access plan for each county within the state in which the HMO operates one (1) or more managed care plans. The initial access plan shall be filed no later than July 1, 1998. Subsequent access plans shall reflect the status of the HMO's managed care plans as of December 31 of each year, and shall be filed no later than February 1 of the following year. The access plan shall meet the requirements of sections 354.400–354.636, RSMo, as well as the network adequacy standards set forth herein, and shall demonstrate that the HMO has an adequate network in each Missouri county in which it is licensed to do business. Network adequacy standards shall apply only to those services offered under the terms of a health benefit plan. Except as otherwise provided by law, the HMO submitting an access or deviation plan may request that all or portions of the information submitted be deemed proprietary, pursuant to procedures set forth in 20 CSR 10-3.100.

(A) Access to Primary Care Providers—the access plan must indicate compliance with the distance standards indicated below, as well as the “Access to Care” standards contained in section (4), when applicable.

1. Distance standards—Compliance with the following distance standards will be achieved if ninety-five percent (95%) of the population of the county (or, at the HMO's option, ninety-five percent (95%) of the enrollees residing or working in the county) is within the distance standard of the providers with whom the HMO contracts:

- A. Urban access counties—10 miles;
- B. Basic access counties—20 miles;

and

- C. Rural access counties—30 miles.

(B) Access to Specialists in Basic Access Counties.

<u>Service/ Specialty</u>	<u>Basic Distance Standard (in miles)</u>
Obstetrics/gynecology	30
Neurology	50
Dermatology	50
Physical medicine/ rehabilitation	50
Podiatry	50
Vision care/primary eye care	30

Medical Subspecialties

Allergy	50
Cardiology	50
Endocrinology	50
Gastroenterology	50
Hematology/oncology	50
Infectious disease	50
Nephrology	50
Ophthalmology	50
Orthopedics	50

Otolaryngology	50
Pediatric	50
Pulmonary disease	50
Rheumatology	50
Urology	50

General Surgery 30

Surgical Subspecialties

Neurosurgery	
Plastic Surgery	
Thoracic Surgery	

Hospital Specialties

Radiology	30
Anesthesiology	50
Pathology	75
Emergency medicine	30

Pediatric Subspecialties

Cardiology	
Endocrinology	
Gastroenterology	
Hematology/oncology	
Infectious disease	
Nephrology	
Pulmonary disease	
Rheumatology	

(C) Access to Specialists in Urban and Rural Access Counties.

1. Urban access counties—The access plan must indicate that ninety-five percent (95%) of a county's population (or, at the HMO's option, ninety-five percent (95%) of the enrollees residing or working in the county) have access to participating providers within one-half (1/2) of the distance standard indicated for specialists under the basic access standard.

2. Rural access counties—The access plan must indicate that ninety-five percent (95%) of a county's population (or, at the HMO's option, ninety-five percent (95%) of the enrollees residing or working in the county) have access to participating providers within twice the distance standard for specialists in basic access counties, or the distance standard for a tertiary hospital, whichever is less.

(D) Hospitals—The following distance standards apply to participating hospitals. In order to achieve compliance, ninety-five percent (95%) of a county's population (or, at the HMO's option, ninety-five percent (95%) of the enrollees residing or working in the county) must live within the distance indicated of a participating facility of each type, regardless of whether the geographical access area is basic, urban, or rural:

- 1. Basic hospital—30 miles;
- 2. Secondary hospital—50 miles; and
- 3. Tertiary hospital—75 miles.

(E) Pharmacies—The distance standards for participating pharmacies are the same as those for primary care providers, as indicated in paragraph (2)(A)1.

(F) Emergency Medical Services—The HMO will have in place and monitor a written triage, treatment and transfer protocol for all ambulance services and acute care hospitals. This document must be available for review by current or prospective enrollees.

(G) Mental Health Providers—The following distance standards shall apply to participating psychiatrists, psychologists, and other licensed mental health care providers located in basic access counties. Distance standards for mental health providers in urban and rural access counties shall be adjusted in accordance with the provisions contained in subsection (2)(C):

<u>Provider</u>	<u>Basic Distance Standard (in miles)</u>
Psychiatrists	
Adult, general	30
Child/adolescent	30
Psychologists/other therapists	20

1. Telephone access to a licensed therapist should be available twenty-four (24) hours per day, seven (7) days per week.

2. Mental/behavioral health facilities—Distance standards for mental/behavioral health facilities in basic access counties are as follows, subject to adjustment for facilities in urban and rural access counties according to the provisions of subsection (2)(C):

A. Outpatient facilities.

(I) Adult—within 20 miles.

(II) Child/adolescent—within 30 miles.

and

(III) Geriatric—within 30 miles;

and

B. Inpatient/intensive treatment facilities.

(I) Adult—within 30 miles.

(II) Child/adolescent—within 50 miles.

and

(III) Geriatric—within 75 miles.

(IV) Alcohol/chemical dependency—within 75 miles.

(H) Dental Health Care—The following distance standards apply only to dental health care providers and facilities whose services are offered to enrollees as part of a major medical HMO plan, and not to prepaid dental plans. The distance standards listed in this section are for those providers and facilities located in basic access counties, subject to adjustment for providers and facilities located in urban and rural access counties, as provided in section (2)(C):



	Basic Distance Standard (in miles)
Provider	
General dentists	30

(I) Chiropractic Care—The following distance standards apply to chiropractic care providers and facilities located in basic access counties, subject to adjustment for providers and facilities located in urban and rural access counties, as provided in subsection (2)(C):

	Basic Distance Standard (in miles)
Provider	
Chiropractors	30

(J) Ancillary Health Care Services—The following standards shall apply for providers of ancillary health care services:

1. Physical therapy—within 30 miles;
2. Occupational therapy—within 30 miles;
3. Speech therapy—within 50 miles;
4. Audiology—within 50 miles;
5. Intermediate care facility (ICF) nursing home—within 50 miles;
6. Skilled nursing facility (SNF) nursing home—within 50 miles;
7. Home health services—must be available in all counties in which plan operates; and
8. Hospice—must be available in all counties in which plan operates.

(3) Network Adequacy Evaluation—In addition to complying with the distance standards contained in section (2) and the “Access to Care” standards contained in section (4), the access plan shall include a section in which the HMO sets forth those standards by which it determines the adequacy of its network, including documentation or evidence that the HMO’s managed care network meets or exceeds those standards.

(4) Access to Care Standards (Primary Care Providers)—A managed care plan which has been doing business in a county for more than one (1) year must show that the plan has implemented administrative measures which would ensure enrollees in that county timely access to appointments, based on the following guidelines:

- (A) Routine care, without symptoms—within thirty (30) days from the time the enrollee contacts the provider;
- (B) Routine care, with symptoms—within one (1) week or five (5) business days from the time the enrollee contacts the provider;

(C) Urgent care for serious, but nonlife-threatening illnesses/injuries—within twenty-four (24) hours from the time the enrollee contacts the provider;

(D) Emergency care for serious and/or life-threatening illnesses or injuries—a provider or emergency care facility shall be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency care; and

(E) Obstetrical care—within one (1) week for enrollees in the first or second trimester of pregnancy; within three (3) days for enrollees in the third trimester. Emergency obstetrical care is subject to the same standards as emergency care, except that an obstetrician must be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency obstetrical care.

(5) Alternative Compliance Mechanisms—Alternatives to the network adequacy standards set forth in section (2) may be submitted to the department for approval under certain conditions, as further described herein.

(A) Different/Reduced Network—An alternative compliance method may be requested by an HMO in those instances where an employer that has contracted with the HMO to provide medical services to its employees pursuant to a managed care plan has requested a different or reduced provider network from the HMO, provided the HMO can demonstrate the adequacy of the different or reduced network with respect to the provision of services to employees enrolled in the plan.

(B) Other Network Adequacy Standards—Health plans offered to enrollees which are subject to other network adequacy standards established by a governmental or quasi-governmental agency may be allowed to demonstrate the adequacy of their network with reference to those standards in lieu of the network adequacy standards contained in section (2). Examples include plans subject to Medicare risk standards, Medicaid standards, and Missouri Consolidated Health Care Plan (MCHCP) standards.

(C) Quality of Care—An HMO may request an alternative compliance method to the distance standards contained in section (2) by submitting an access plan which is designed to significantly enhance the quality of care to enrollees, and which does in fact enhance the quality of care. Alternative compliance methods based on this section must impose no greater cost on enrollees than would be incurred if they had access to an in-network provider meeting the distance standards contained in section (2).

(D) Noncompetitive Market Exception for PCPs and Pharmacies—In the event an HMO can demonstrate to the department that there

is not a competitive market among PCPs and/or pharmacies who meet the HMO’s credentialing standards, and who are qualified within the scope of their professional license to provide appropriate care and services to enrollees, the department may approve an alternative compliance method to double the distance standard indicated in section (2) for the type of provider or pharmacy.

(E) Noncompetitive Market Exception for Hospitals and Specialists—If no hospital or specialist of the appropriate type provides services to enrollees of an HMO in a county within the distance standards indicated in section (2), the HMO may submit an alternative compliance method request to the department. The request shall demonstrate that no fewer than ninety-five percent (95%) of the population of that county (or, at the HMO’s discretion, ninety-five percent (95%) of the enrollees residing or working in the county) have access to a participating hospital or specialist of the appropriate type, which hospital or specialist is located no more than twenty-five (25) miles further than the hospital or specialist closest to that county.

(F) The department may approve an exception to geographic network adequacy requirements for those health care services provided to enrollees by an HMO if substantially all of those services are provided by the HMO to its enrollees through qualified full-time employees of the HMO or qualified full-time employees of a medical group that does not provide substantial health care services other than on behalf of such HMO. In order to qualify for the exception provided for in this section, an HMO must demonstrate that all or substantially all of the type of health care services in question are provided by full-time employees, that enrollees have adequate access to such health care services, and that the contract holder was made aware of the circumstances under which such services were to be provided prior to the decision to contract with the HMO.

(G) The standard by which the department will review alternative compliance method requests is whether or not the alternative compliance method, taken as a whole, is to the benefit of the enrollee.

(6) Reporting Identity and Number of Providers—For primary care providers, physician assistants, advanced nurse practitioners, residents, interns, chiropractors, and those specialists and facilities listed in subsections (2)(B), (E), (F), (G), (H), and (J), the access plan shall report the following information:

- (A) The name, business address, zip code, professional license number, and specialty or degree of each provider;

(B) The number of other practice affiliations reported by each provider on the provider's standardized credentialing form; and

(C) Whether or not the provider is a closed practice provider, as defined in subsection (1)(B).

(7) Enforcement of Standards. The network adequacy standards set forth herein are minimum standards designed to assure that all services provided to enrollees shall be available without delay. HMOs must demonstrate compliance with these standards, or an alternative compliance method, at the time of issuance and renewal of their certificate of authority.

(A) HMOs which fail to demonstrate compliance with network adequacy standards or an alternative compliance method at the time of their initial and/or renewal application may have their application denied or their certificate non-renewed until such time as they demonstrate compliance or obtain approval of an alternative compliance method.

(B) HMOs which fail to maintain network adequacy standards while possessing a certificate of authority, unless an alternative compliance method has been approved, shall be placed on probationary status by the department for a period not to exceed ninety (90) days, during which time the HMO shall take appropriate measures to achieve compliance. If compliance is achieved prior to the expiration of the probationary period, the HMO will be removed from probationary status.

(C) If an HMO which is on probation for noncompliance fails to achieve compliance by the end of the probationary period, the department may order the HMO to refrain from writing new business for a period of up to ninety (90) days following the expiration of the probationary period in those counties in which the HMO is operating one (1) or more noncompliant plans.

(D) If an HMO fails to achieve compliance within the ninety (90)-day period following the expiration of the probationary period, the HMO may be ordered to refrain from writing new business within the state of Missouri until such time as compliance has been achieved and verified by the Department of Insurance.

(E) HMOs must report changes in their network or number of enrollees to the director of insurance if and when such changes cause one (1) or more of the HMO's managed care plans to be in non-compliance with any of the applicable network adequacy standards contained herein.

AUTHORITY: sections 354.405, 354.603 and 354.615, RSMo Supp. 1997. Original rule filed Nov. 3, 1997, effective May 30, 1998.*

**Original authority: 354.405, RSMo 1983, amended 1997; 354.603, RSMo 1997; and 354.615, RSMo 1997.*

20 CSR 400-7.100 Copayments

PURPOSE: This rule states that an health maintenance organization may require copayments of its enrollees as a condition for the receipt of health care services. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

A health maintenance organization (HMO) may require copayments of its enrollees as a condition of the receipt of specific health care services. An HMO may not impose copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty percent (20%) of the total cost of providing all basic health services. An HMO may not impose copayment charges for basic health care services on any enrollee in any calendar year after the copayments made by the enrollee in that calendar year for basic health care services total two hundred percent (200%) of the total annual premium which is required to be paid by, or on behalf of, that enrollee and shall be stated as a dollar amount in the group contracts. Copayments shall be the only allowable charge, other than premiums, assessed to enrollees for basic and supplemental health care services. Single service copayment amounts shall be disclosed either as a percentage or as a stated dollar amount in the evidence of coverage. For group contracts the copayment amount may be changed only on the anniversary date of the group contract except by mutual agreement of the parties to the contract.

AUTHORITY: sections 354.430 and 354.485, RSMo 1986. This rule was previously filed as 4 CSR 190-15.190. Original rule filed Nov. 2, 1987, effective April 11, 1988. Amended: Filed Aug. 16, 1989, effective Dec. 15, 1989.*

**Original authority 1983.*

20 CSR 400-7.110 Health Maintenance Organizations—Resolution of Enrollee Grievances

PURPOSE: This rule sets forth the guidelines and procedures to be used by a health maintenance organization to resolve enrollee grievances. This rule is promulgated pursuant to section 354.485, RSMo and implements

sections 354.430.3(2)(e) and 354.445, RSMo.

(1) Definitions.

(A) Grievance means a complaint submitted in writing in accordance with the health maintenance organization's (HMO) formal grievance procedure by or on behalf of the enrollee regarding the interpretation of the certificate of coverage or dissatisfaction with the quality of health care provided by an HMO employee or a contracted provider.

(B) Grievance advisory panel means a panel established by the HMO which may review the HMO's decision regarding grievances which have not been resolved to the satisfaction of the enrollee and which an enrollee has requested the panel to review. This panel must be comprised, at least in part, of enrollees and also may include representatives from the HMO, but shall not include anyone involved in the circumstances giving rise to the grievance, or in any subsequent investigation or determination of the grievance placed before it.

(2) An HMO shall set forth in its certificate of coverage the procedures for resolving enrollee grievances. At a minimum, the certificate of coverage shall include the following provisions:

(A) The definition of a grievance;

(B) How, where and to whom the enrollee should file his/her grievance; and

(C) That upon receiving notification of a grievance related to payment of a bill for medical services, the HMO will—

1. Acknowledge receipt of the grievance in writing within ten (10) working days unless it is resolved within that period of time;

2. Conduct a complete investigation of the grievance within twenty (20) working days after receipt of a grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty (20) working days after receipt of a grievance, the enrollee shall be notified in writing within thirty (30) working days time, and every thirty (30) working days after that, until the investigation is completed. The notice shall set forth the reasons for which additional time is needed for the investigation;

3. Have within five (5) working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the HMO's decision regarding the grievance and of any right to appeal. The notice shall explain the resolution of the grievance and

any right to appeal. The notice shall explain the resolution of the grievance in terms which are clear and specific; and

4. Notify, if the HMO has established a grievance advisory panel, the enrollee of his/her right to request the grievance advisory panel to review the HMO's decision. This notice shall indicate that the grievance advisory panel is not obligated to conduct the review. This provision shall also state how, where and when the enrollee should make his/her request for this review.

(3) An HMO shall keep a record or report of the total number, type, nature and result of all grievances. Upon request by the director of the Department of Insurance or his/her appointee, the HMO shall provide, promptly, all those records or reports.

(4) An HMO, upon receipt of any inquiry from the Department of Insurance regarding a grievance, within fifteen (15) working days of receipt of the inquiry, shall furnish the department with a written response to the information requested.

(5) All written grievances shall be date stamped when received by the HMO. The date shall be legible and easily identified.

(6) The director of the Department of Insurance may institute disciplinary action for a violation of this rule in accordance with the provisions of section 354.550, RSMo and any other applicable law.

AUTHORITY: sections 354.430, 354.445 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority 1983.*

20 CSR 400-7.120 Health Maintenance Organization—Enrollee Participation

PURPOSE: This rule sets forth the health maintenance organization's method for enrollees to participate in matters of policy and operation. This rule is promulgated pursuant to section 354.485, RSMo and implements section 354.420, RSMo.

(1) Definitions.

(A) Enrollee means an individual who is covered by a health maintenance organization (HMO).

(B) Evidence of coverage means any certificate, agreement or contract issued to an enrollee which sets out the coverage to which the enrollee is entitled under the HMO contract which covers the enrollee.

(2) Enrollee Participation. Every HMO shall establish a mechanism which affords enrollees an opportunity to participate in matters of the HMO's policy and operation. The HMO in its evidence of coverage shall clearly advise the member that a mechanism which affords enrollees an opportunity to participate in matters of the HMO's policy and operation, and which has been approved by the Missouri Department of Insurance, will be made available to this member upon request. At a minimum, the mechanism used must both afford enrollees an opportunity to offer appropriate suggestions to the policymaking body of the HMO and ensure that the policymaking body gives these suggestions due consideration, and either approves or disapproves them. For purposes of this section, suggestions deemed appropriate for presentation to the policymaking body shall be those selected by either an enrollee advisory committee, the composition of which is set forth in the HMO's organizational documents or such other means as have been approved by the director.

(3) Discipline. The director of the Department of Insurance may institute disciplinary action for a violation of this rule in accordance with the provisions of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.420 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority 1983.*

20 CSR 400-7.130 Authorization for Emergency Medical Services

PURPOSE: This rule sets forth the requirements of a health maintenance organization when prior authorization for emergency medical services is required. This rule is promulgated pursuant to section 354.485, RSMo and implements sections 354.410.1(2) and 354.470.1(3), RSMo.

(1) A health maintenance organization (HMO) that requires prior authorization before making payment for the treatment of medical emergency conditions, as defined by the HMO, shall provide enrollees with a toll-free telephone number answered twenty-four (24) hours per day, seven (7) days a week. At least one (1) person with medical training who is authorized to determine whether an emergency condition exists shall be available twenty-four (24) hours per day, seven (7) days a week to make these determinations.

(2) An HMO shall not base its denial of payment for emergency medical services solely on the enrollee's failure to receive authorization prior to receiving the emergency medical service. The enrollee must notify the HMO of receipt of medical services for emergency conditions within twenty-four (24) hours or as soon after that as is reasonably possible. Nothing shall require the HMO to authorize payment for any services provided during that twenty-four (24)-hour period, regardless of medical necessity, if those services do not otherwise constitute benefits under the certificate of coverage approved by the department.

(3) If the participating provider is responsible for seeking prior authorization from the HMO before receiving payment for the treatment of emergency medical conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency medical services has not been sought and received, other than for what s/he would otherwise be responsible, such as copayments and deductibles.

(4) All disputes between an enrollee and an HMO arising under the provisions of this regulation shall be resolved by means of the HMO's grievance procedure.

(5) Discipline. The director of the Department of Insurance may institute disciplinary action for violation of this rule in accordance with the provisions of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.410, 354.470 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority 1983.*

20 CSR 400-7.140 Health Maintenance Organizations—Reinsurance Agreements

PURPOSE: This rule sets forth the requirements that relate to the filing of reinsurance agreements with the Department of Insurance. This rule is promulgated pursuant to section 354.485, RSMo and implements sections 354.405.5. and 354.410.1(3)(c) and (6), RSMo.

(1) Definition. As used in this rule, a contract of reinsurance means the entire contract, including the signatures of the representatives of the health maintenance organization

(HMO) and the reinsurer, and any binders, certificates, attachments, amendments or modifications to the contract.

(2) Filing. A contract of reinsurance shall be submitted to the Department of Insurance for filing and approval no later than ten (10) working days after receipt by the HMO. If it appears there will be a substantial delay between the issuance of a binder and all other documents connected with the contract of reinsurance, or difficulty in obtaining a contract of reinsurance as evidenced by the negotiation process, the HMO shall file a copy of the binder or a letter signed by an officer of the reinsurer explaining the circumstances pertaining to the delay. After filing this binder or letter, the HMO shall file its contract of reinsurance ten (10) working days after receipt of the contract. Proof of coverage shall be filed no later than ten (10) working days after its effective date.

(3) Provisions. A contract of reinsurance shall not contain a provision stating that the contract of reinsurance will not apply or will become ineffective in the event the HMO is unable to meet its financial obligations or is insolvent.

(4) Requests. Upon request by the director of the Department of Insurance or his/her appointee, the HMO shall provide promptly to the Department of Insurance all contracts of reinsurance required by this section and available to the HMO.

(5) Discipline. The director of the Department of Insurance may institute disciplinary action for violation of this rule in accordance with the provisions of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.405, 354.410 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority 1983.*

20 CSR 400-7.150 Health Maintenance Organizations—Disenrollments

PURPOSE: This rule specifies when a health maintenance organization may disenroll an enrollee for nonpayment of a copayment when his/her premium has been paid. This rule is promulgated pursuant to section 354.485, RSMo and implements section 354.462, RSMo.

(1) Definitions.

(A) Copayment means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

(B) Copayment maximum means the total amount of copayments an enrollee is obligated to pay during the calendar year as defined by the contract.

(C) Disenrollment means a health maintenance organization's (HMO) termination of an enrollee's eligibility for service.

(D) Enrollee means an individual who is properly enrolled in an HMO.

(2) Disenrollment. An enrollee for whom premium has been paid may not be disenrolled nor denied renewal for nonpayment of a copayment except when the HMO or provider to whom the copayment is due has initiated collection efforts within sixty (60) days after the HMO is notified that copayment is due. The enrollee also must receive written notice from the HMO stating the disenrollment will occur unless arrangements for payment of the copayment are made within ten (10) working days after receipt of the notice.

(3) Refunds. An HMO shall refund any premium payment, net of copayments due, made to cover the period after disenrollment.

(4) Copayment Notification. Upon request, an HMO shall inform an enrollee if s/he has reached his/her copayment maximum.

(5) Discipline. The director of the Department of Insurance may institute disciplinary action for a violation of this rule in accordance with the provision of section 354.500, RSMo and any other applicable law.

AUTHORITY: sections 354.462 and 354.485, RSMo 1986. Original rule filed April 14, 1992, effective Feb. 26, 1993.*

**Original authority 1983.*

20 CSR 400-7.160 Multiple Names Prohibited

PURPOSE: This rule implements the provisions of sections 354.405, 354.460, 375.934 and 375.936(4), RSMo regarding the name of a health maintenance organization and misleading information and advertising. This rule prohibits an health maintenance organization from using any name other than its true name on its certificate of authority and sets forth specific requirements for the use of multiple names on its other documents and publications.

(1) A health maintenance organization (HMO) must use its true name for its certificate of authority to conduct business as an HMO in this state.

(2) An HMO will be permitted to use a fictitious name, an acronym or a portion of its true name, in its advertising, agreements, contracts, policies, evidences of coverage, filings with the director or any other publication of its name, provided that the HMO uses its true name at least once in each advertisement, agreement, contract, policy, evidence of coverage, filing with the director, or any other publication of its name.

(3) Any HMO which does business as an HMO in this state under a fictitious name shall file with the director a copy of all documents, including the authorization from the Missouri secretary of state, which shows the legal authority for the HMO to use such other name. Any acronym or portion of the true name must be registered with the director.

(4) Any HMO which prior to the effective date of this rule used or employed more than one (1) name shall cease using more than one (1) name, except as permitted by this rule, and take all steps necessary to comply with this rule within sixty (60) days after the effective date of this rule (June 6, 1994), including but not limited to, the filing of an application for an amended certificate of authority to reflect the true name of the HMO and the payment of fees in accordance with section 354.495, RSMo.

(5) The director may institute disciplinary action for violations of this rule in accordance with the provisions of sections 354.490, 354.500, 374.046 and 375.942, RSMo and any other applicable law.

AUTHORITY: section 374.045, RSMo Supp. 1993. Original rule filed Oct. 1, 1993, effective June 6, 1994.*

**Original authority 1967, amended 1993.*

20 CSR 400-7.170 Distribution of Written Disclosure Information

PURPOSE: This rule sets forth with greater specificity the enrollees who are entitled to written disclosure information. This rule is promulgated pursuant to section 354.485, RSMo, and implements section 354.442.1, RSMo.

(1) Definition. As used in this rule, a household means those persons who dwell under



the same roof and are covered by the same policy.

(2) If a household includes more than one (1) enrollee, a health maintenance organization is only required to provide one (1) written disclosure to that household.

AUTHORITY: sections 354.442.1, RSMo Supp. 1997 and 354.485, RSMo 1994. Original rule filed Nov. 3, 1997, effective June 30, 1998.

**Original authority: 354.442, RSMo 1997 and 354.485, RSMo 1983.*

(5) A health carrier may require a health care professional to sign an affirmation and release of the health carrier’s own design.

AUTHORITY: sections 354.442.1(15), RSMo Supp. 1997 and 354.485, RSMo 1994. Original rule filed Nov. 3, 1997, effective June 30, 1998.

**Original authority: 354.442, RSMo 1997 and 354.485, RSMo 1983.*

20 CSR 400-7.180 Standard Form To Establish Credentials

PURPOSE: This rule sets forth the standard form which shall be used by all health carriers when soliciting the credentials of a health care professional in a managed care plan. This rule is promulgated pursuant to section 354.485, RSMo, and implements section 354.442.1(15), RSMo.

(1) Definitions.

(A) Health care professional means a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law.

(B) Health carrier means a health maintenance organization as organized pursuant to sections 354.400 through 354.636, RSMo.

(C) Managed care plan means a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the health carrier.

(2) The form provided in Exhibit A shall be used by all health carriers and their agents when credentialing or recredentialing health care professionals in a managed care plan.

(3) Health carriers may request additional information to explain or provide details regarding responses obtained on the standard form. Health carriers are prohibited from routinely requiring additional information from health care professionals.

(4) An on-site examination by the health carrier or their agent of the health care professional’s place of business shall not, in itself, be considered a routine request for additional information.