FIRST REGULAR SESSION

HOUSE BILL NO. 796

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES LAMPE (Sponsor) AND GRISAMORE (Co-sponsor).

1650L.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 376.779, 376.810, 376.811, 376.814, 376.825, 376.826, 376.827, 376.830, 376.833, 376.836, and 376.1550, RSMo, and to enact in lieu thereof one new section relating to mental health insurance coverage.

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

Section A. Sections 376.779, 376.810, 376.811, 376.814, 376.825, 376.826, 376.827, 376.830, 376.833, 376.836, and 376.1550, RSMo, are repealed and one new section enacted in lieu thereof, to be known as section 376.1550, to read as follows:

376.1550. 1. Notwithstanding any other provision of law to the contrary, each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a mental health condition, as defined in this section, and shall comply with the following provisions:

(1) **Except for the limitations specified in this section which may be applied only when permissible under federal parity requirements,** a health benefit plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required by a health carrier or health benefit plan shall be comprehensive for coverage of all health conditions, whether mental or physical;

(2) The coverages set forth is this subsection:

(a) May be administered pursuant to a managed care program established by the health carrier; and

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.

(b) May deliver covered services through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities**, including but not limited to entities** certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri;

(3) A health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions may provide coverage for treatment of mental health conditions through a managed care organization; provided that the managed care organization is in compliance with rules adopted by the department of insurance, financial institutions and professional registration that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the director shall assure that:

(a) Timely and appropriate access to care is available;

(b) The quantity, location, and specialty distribution of health care providers is adequate; and

(c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured;

(4) **[**Coverage for treatment for chemical dependency shall comply with sections 376.779, 376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to 376.836, the term "health insurance policy" shall include group coverage**] If permissible under federal parity requirements, coverage for inpatient or residential treatment of alcoholism may be limited to thirty days or to the total number of days that represents the most current standard of care, whichever is greater;**

(5) Coverage for substance use disorder may be limited as follows if permissible under federal parity requirements:

(a) Coverage for outpatient treatment through a nonresidential treatment program or through partial- or full-day program services may be limited to twenty-six days per policy benefit period;

(b) Coverage for residential treatment programs may be limited to twenty-one days per policy benefit period;

(c) Coverage for medical or social setting detoxification may be limited to six days per policy benefit period;

(d) Coverage for substance use disorder may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment; except that, such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation as

determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the health carrier;

(6) (a) A health benefit plan shall provide coverage for the diagnosis and treatment of autism spectrum disorders.

(b) To the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by a health benefit plan, the coverage required under this subdivision shall be included in health benefit plans that are delivered, executed, issued, amended, adjusted, or renewed on or after August 28, 2009.

(c) a. Coverage provided under this subdivision is limited to treatment that is ordered by the enrollee's treating licensed physician or licensed psychologist under the authority granted under such physician's or psychologist's license and in accordance with a treatment plan.

b. If requested by the health carrier or required under the health benefit plan, the treatment plan shall include all elements necessary to appropriately pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency, and duration of treatment, and goals.

c. Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, the health carrier shall have the right to request a review of such treatment not more than once every six months, unless the health carrier and treating physician or psychologist agree that a more frequent review is necessary. The cost of obtaining any review shall be the responsibility of the health carrier.

(d) a. Health benefit plans shall provide coverage for applied behavior analysis for individuals less than twenty-one years of age if the treatment plan indicates that applied behavior analysis is appropriate.

b. If permissible under federal parity requirements, coverage for applied behavior analysis shall be subject to a maximum benefit of seventy-two thousand dollars per year, but shall not be subject to any limits on the number of visits by an individual to an autism service provider for applied behavior analysis. After December 31, 2010, the director of the department of insurance, financial institutions and professional registration shall annually adjust the maximum benefit for applied behavior analysis for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Inflation adjustments shall be announced no later than December first of each year and shall be effective on January first of the following year.

c. Coverage provided under this subdivision for services other than applied behavior analysis shall not be subject to any limits on the number of visits an individual may make to an autism service provider.

d. To the extent any payments or reimbursements are being made for services rendered by a direct implementer for applied behavior analysis, such payments or reimbursements shall be made to:

(i) The person who is supervising the direct implementer who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board; or

(ii) The entity or group for whom such supervising person works or is associated.

e. Payments made by a health carrier on behalf of a covered individual for anything other than applied behavior analysis shall not be applied toward any maximum benefit established under subparagraph b. of this paragraph.

2. As used in this section, the following terms mean:

(1) **[**"Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both**] "Applied behavior analysis", the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior;**

(2) "Autism service provider":

(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri;

(b) Any person who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board;

(c) Any person, if not licensed or certified, who shall provide, if requested, documented evidence of equivalent education, professional training, and supervised experience in applied behavior analysis when the treatment provided by the autism service provider is applied behavior analysis; or

(d) A direct implementer;

(3) "Autism spectrum disorders", the same meaning as such term is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

(4) "Day program services", a structured intensive day or evening treatment or partial hospitalization program;

(5) "Diagnosis of a mental condition" or "diagnosis of autism spectrum disorders", assessments, evaluations, or tests necessary to diagnose an individual with a mental health condition, including diagnosis of autism spectrum disorders;

(6) "Direct implementer", any person who provides diagnostic or treatment services for autism spectrum disorders who is not licensed or certified, as described in paragraphs (a) and (b) of subdivision (2) of this subsection, and is supervised by a person who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board, whether such analyst supervises as an individual or as an employee or in association with an entity or group;

(7) "Episode", a distinct course of substance use disorder treatment separated by at least thirty days without treatment;

[(2)**] (8)** "Health benefit plan", the same meaning as such term is defined in section 376.1350;

[(3)**] (9)** "Health carrier", the same meaning as such term is defined in section 376.1350;

[(4)**] (10)** "Mental health condition", any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders **[**except for chemical dependency**]**;

[(5)**] (11) "Managed care", the determination of availability of coverage under a health benefit plan through the use of clinical standards to determine the medical necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective concurrent or retrospective basis, sometimes involving case management;**

(12) "Managed care organization", any financing mechanism or system that manages care delivery for its members or subscribers, including health maintenance organizations and any other similar health care delivery system or organization;

[(6)**] (13) "Medical detoxification", hospital inpatient or residential medical care to ameliorate acute medical conditions associated with substance use disorder;**

(14) "Nonresidential treatment program", a program involving structured intensive treatment in a nonresidential setting;

(15) "Rate, term, or condition", any lifetime or annual payment limits, deductibles, co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of a health benefit plan that affects the insured**;**

(16) "Residential treatment program", a program involving structured intensive treatment in a residential setting;

(17) "Social setting detoxification", a program in a supportive nonhospital setting designed to achieve detoxification without the use of drugs or other medical intervention to establish a plan of treatment and provide for medical referral when necessary;

(18) "Substance use disorder", the psychological or physiological dependence upon and abuse of drugs, including alcohol which is characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning, or both;

(19) "Treatment of a mental condition" or "treatment of autism spectrum disorders", care prescribed, provided, or ordered for an individual diagnosed with a mental health condition, including an autism spectrum disorder, by a licensed physician or psychologist under the authority granted under such physician's or psychologist's license, if the care is determined to be medically necessary, including but not limited to:

(a) Applied behavior analysis as defined in this subsection;

(b) Psychiatric care. "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

(c) Psychological care. "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

(d) Habilitative or rehabilitative care. "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore the functioning of an individual;

(e) Therapeutic care. "Therapeutic care" means services provided by licensed speech therapists, occupational therapists, or physical therapists;

(f) Pharmacy care. "Pharmacy care" means medications or nutritional supplements used to address symptoms of a mental health condition, including an autism spectrum disorder, prescribed by a licensed physician and any health-related services necessary to determine the need or effectiveness of the medications or nutritional supplements.

3. This section shall not apply to **[**a health plan or policy that is individually underwritten or provides such coverage for specific individuals and members of their families pursuant to section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836,**]** a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy **which is not specifically a policy for coverage of a mental health condition**, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policies of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

4. Notwithstanding any other provision of law to the contrary, all health insurance policies that cover state employees, including the Missouri consolidated health care plan, shall include coverage for mental illness. Multiyear group policies need not comply until the

expiration of their current multiyear term unless the policyholder elects to comply before that time.

5. The provisions of this section shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

(1) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

(2) Services rendered or billed by a school or halfway house;

(3) Care that is custodial in nature;

(4) Services and supplies that are not immediately nor clinically appropriate; or

(5) Treatments that are considered experimental**; except that, applied behavior analysis shall not be considered experimental**.

6. The director shall grant a policyholder a waiver from the provisions of this section if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with this section has increased the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder. The director shall promulgate rules establishing a procedure and appropriate standards for making such a demonstration. 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, section 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 are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

7. A health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, reissue, or otherwise terminate or restrict coverage on an individual or such individual's dependent solely because such individual or dependent is diagnosed with a mental health condition, including an autism spectrum disorder. A health carrier shall not deny, delay, or reduce payment for otherwise covered services solely because an individual or an individual's dependent is diagnosed with a mental health condition, including an autism spectrum disorder.

8. Any violation of this section shall be considered a level two violation under section 374.049, RSMo.

[376.779. 1. All health plans or policies that are individually underwritten or provide for such coverage for specific individuals and the members of their families, which provide for hospital treatment, shall provide coverage, while confined in a hospital or in a residential or nonresidential facility

certified by the department of mental health, for treatment of alcoholism on the same basis as coverage for any other illness, except that coverage may be limited to thirty days in any policy or contract benefit period. All Missouri individual contracts issued on or after January 1, 2005, shall be subject to this section. Coverage required by this section shall be included in the policy or contract and payment provided as for other coverage in the same policy or contract notwithstanding any construction or relationship of interdependent contracts or plans affecting coverage and payment of reimbursement prerequisites under the policy or contract.

2. Insurers, corporations or groups providing coverage may approve for payment or reimbursement vendors and programs providing services or treatment required by this section. Any vendor or person offering services or treatment subject to the provisions of this section and seeking approval for payment or reimbursement shall submit to the department of mental health a detailed description of the services or treatment program to be offered. The department of mental health shall make copies of such descriptions available to insurers, corporations or groups providing coverage under the provisions of this section. Each insurer, corporation or group providing coverage shall notify the vendor or person offering service or treatment as to its acceptance or rejection for payment or reimbursement; provided, however, payment or reimbursement shall be made for any service or treatment program certified by the department of mental health. Any notice of rejection shall contain a detailed statement of the reasons for rejection and the steps and procedures necessary for acceptance. Amended descriptions of services or treatment programs to be offered may be filed with the department of mental health. Any vendor or person rejected for approval of payment or reimbursement may modify their description and treatment program and submit copies of the amended description to the department of mental health and to the insurer, corporation or group which rejected the original description.

3. The department of mental health may issue rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024, RSMo.

4. All substance abuse treatment programs in Missouri receiving funding from the Missouri department of mental health must be certified by the department.

5. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.**]**

[376.810. As used in sections 376.810 to 376.814, the following terms mean:

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both;

(2) "Community mental health center", a legal entity certified by the department of mental health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals;

(3) "Day program services", a structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization;

(4) "Episode", a distinct course of chemical dependency treatment separated by at least thirty days without treatment;

(5) "Health insurance policy", all health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and members of their families, which provide for hospital treatment. For the purposes of subsection 2 of section 376.811, "health insurance policy" shall also include any individually underwritten coverage issued by a health maintenance organization. The provisions of sections 376.810 to 376.814 shall not apply to policies which provide coverage for a specified disease only, other than for mental illness or chemical dependency;

(6) "Licensed professional", a licensed physician specializing in the treatment of mental illness, a licensed psychologist, a licensed clinical social worker or a licensed professional counselor. Only prescription rights under this act shall apply to medical physicians and doctors of osteopathy;

(7) "Managed care", the determination of availability of coverage under a health insurance policy through the use of clinical standards to determine the medical necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective, concurrent or retrospective basis, sometimes involving case management;

(8) "Medical detoxification", hospital inpatient or residential medical care to ameliorate acute medical conditions associated with chemical dependency;

(9) "Nonresidential treatment program", a program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting;

(10) "Recognized mental illness", those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, but shall not include mental retardation;

(11) "Residential treatment program", a program certified by the department of mental health involving residential care and structured, intensive treatment;

(12) "Social setting detoxification", a program in a supportive nonhospital setting designed to achieve detoxification, without the use of drugs or other medical intervention, to establish a plan of treatment and provide for medical referral when necessary.**]**

[376.811. 1. Every insurance company and health services corporation doing business in this state shall offer in all health insurance policies benefits or coverage for chemical dependency meeting the following minimum standards:

(1) Coverage for outpatient treatment through a nonresidential treatment program, or through partial- or full-day program services, of not less than twenty-six days per policy benefit period;

(2) Coverage for residential treatment program of not less than twenty-one days per policy benefit period;

(3) Coverage for medical or social setting detoxification of not less than six days per policy benefit period;

(4) The coverages set forth in this subsection may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation as determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the insurance company or health services corporation; and

(5) The coverages set forth in this subsection:

(a) Shall be subject to the same coinsurance, co-payment and deductible factors as apply to physical illness;

(b) May be administered pursuant to a managed care program established by the insurance company or health services corporation; and

(c) May deliver covered services through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

2. In addition to the coverages set forth in subsection 1 of this section, every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies, benefits or coverages for recognized mental illness, excluding chemical dependency, meeting the following minimum standards:

(1) Coverage for outpatient treatment, including treatment through partial- or full-day program services, for mental health services for a recognized mental illness rendered by a licensed professional to the same extent as any other illness;

(2) Coverage for residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness;

(3) Coverage for inpatient hospital treatment for a recognized mental illness to the same extent as for any other illness, not to exceed ninety days per year;

(4) The coverages set forth in this subsection shall be subject to the same coinsurance, co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical illness; and

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the group or individual policyholder or contract holder and, if accepted, shall fully and completely satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to 376.814 shall prohibit an insurance company, health services corporation or health maintenance organization from including all or part of the coverages set forth in sections 376.810 to 376.814 as standard coverage in their policies or contracts issued in this state.

4. Every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies mental health benefits or coverage as part of the policy or as a supplement to the policy. Such mental health benefits or coverage shall include at least two sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker acting within the scope of such license and under the following minimum standards:

(1) Coverage and benefits in this subsection shall be for the purpose of diagnosis or assessment, but not dependent upon findings; and

(2) Coverage and benefits in this subsection shall not be subject to any conditions of preapproval, and shall be deemed reimbursable as long as the provisions of this subsection are satisfied; and

(3) Coverage and benefits in this subsection shall be subject to the same coinsurance, co-payment and deductible factors as apply to regular office visits under coverages and benefits for physical illness.

5. If the group or individual policyholder or contract holder rejects the offer required by this section, then the coverage shall be governed by the mental health and chemical dependency insurance act as provided in sections 376.825 to 376.836.

6. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.**]**

[376.814. 1. The department of insurance, financial institutions and professional registration shall promulgate rules and regulations, pursuant to section 376.982 and chapter 536, RSMo, and the department of mental health shall advise the department of insurance, financial institutions and professional registration on the promulgation of said rules and regulations as they pertain to the development and implementation of all standards and guidelines for managed care as set out in sections 376.810 to 376.814, to ensure that all mental health services provided pursuant to sections 376.810 to 376.814 are provided in accordance with chapters 197, 334, 337, RSMo, and section 630.655, RSMo, provided however, that nothing in this act shall prohibit department of mental health licensed or certified facilities or programs from using qualified mental health professionals or other specialty staff persons.

2. Any person who serves or served on a quality assessment and assurance committee required under 42 U.S.C. Sec. 1396r(b)(1)(B) and 42 CFR Sec. 483.75(r), or as amended, shall be immune from civil liability only for acts done directly as a member of such committee so long as the acts are performed in good faith, without malice and are required by the activities of such committee as defined in 42 CFR Sec. 483.75(r).**]**

[376.825. Sections 376.825 to 376.840 shall be known and may be cited as the "Mental Health and Chemical Dependency Insurance Act".**]**

[376.826. For the purposes of sections 376.825 to 376.836 the following terms shall mean:

(1) "Director", the director of the department of insurance, financial institutions and professional registration;

(2) "Health insurance policy" or "policy", all health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and members of their families, which provide for hospital treatments. The term shall also include any individually underwritten coverage issued by a health maintenance organization. The provisions of sections 376.825 to 376.836

shall not apply to policies which provide coverage for a specified disease only, other than for mental illness or chemical dependency;

(3) "Insurer", an entity licensed by the department of insurance, financial institutions and professional registration to offer a health insurance policy;

(4) "Mental illness", the following disorders contained in the International Classification of Diseases (ICD-9-CM):

(a) Schizophrenic disorders and paranoid states (295 and 297, except 297.3);

(b) Major depression, bipolar disorder, and other affective psychoses (296);

(c) Obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81);

(d) Early childhood psychoses, and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81 and 314);

(e) Alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); and

(f) Anorexia nervosa, bulimia and other severe eating disorders (307.1, 307.51, 307.52 and 307.53);

(g) Senile organic psychotic conditions (290);

(5) "Rate", "term", or "condition", any lifetime limits, annual payment limits, episodic limits, inpatient or outpatient service limits, and out-of-pocket limits. This definition does not include deductibles, co-payments, or coinsurance prior to reaching any maximum out-of-pocket limit.

Any out-of-pocket limit under a policy shall be comprehensive for coverage of mental illness and physical conditions.**]**

[376.827. 1. Nothing in this bill shall be construed as requiring the coverage of mental illness.

2. Except for the coverage required pursuant to subsection 1 of section 376.779, and the offer of coverage required pursuant to sections 376.810 through 376.814, if any of the mental illness disorders enumerated in subdivision (4) of section 376.826 are provided by the health insurance policy, the coverage provided shall include all the disorders enumerated in subdivision (4) of section 376.826 and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to evaluation and treatment for mental illness than for access to evaluation and treatment for physical conditions, generally, except that alcohol and other drug abuse services shall have a minimum of thirty days total inpatient treatment and a minimum of twenty total visits for outpatient treatment for each year of coverage. A lifetime limit equal to four times such annual limits may be imposed. The days allowed for inpatient treatment can be converted for use for outpatient treatment on a two-for-one basis.

3. Deductibles, co-payment or coinsurance amounts for access to evaluation and treatment for mental illness shall not be unreasonable in relation to the cost of services provided.

4. A health insurance policy that is a federally qualified plan of benefits shall be construed to be in compliance with sections 376.825 to 376.836 if the policy is issued by a federally qualified health maintenance organization and the federally qualified health maintenance organization offered mental health coverage as required by sections 376.825 to 376.836. If such coverage is rejected, the federally qualified health maintenance organization shall, at a minimum, provide coverage for mental health services as a basic health service as required by the Federal Public Health Service Act, 42 U.S.C. Section 300e., et seq.

5. Health insurance policies that provide mental illness benefits pursuant to sections 376.825 to 376.840 shall be deemed to be in compliance with the requirements of subsection 1 of section 376.779.

6. The director may disapprove any policy that the director determines to be inconsistent with the purposes of this section.**]**

[376.830. 1. The coverages set forth in sections 376.825 to 376.840 may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more licensed providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri. Nothing in this section shall authorize any unlicensed provider to provide covered services.

2. An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and clinically appropriate care and treatment for each patient.

3. Nothing in sections 376.825 to 376.840 shall be construed to require a managed care plan as defined by section 354.600, RSMo, when providing coverage for benefits governed by sections 376.825 to 376.840, to cover services rendered by a provider other than a participating provider, except for the coverage pursuant to subsection 4 of section 376.811. An insurer may contract for benefits provided in sections 376.825 to 376.840 with a managing entity or group of providers for the management and delivery of services for benefits governed by sections 376.825 to 376.840.**]**

[376.833. 1. The provisions of section 376.827 shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

(1) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

(2) Services rendered or billed by a school or halfway house;

(3) Care that is custodial in nature;

(4) Services and supplies that are not medically necessary nor clinically appropriate; or

(5) Treatments that are considered experimental.

2. The director shall grant a policyholder a waiver from the provisions of section 376.827 if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with sections 376.825 to 376.840 has increased the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder.**]**

[376.836. 1. The provisions of sections 376.825 to 376.836 apply to applications for coverage made on or after January 1, 2005, and to health insurance policies issued or renewed on or after such date to residents of this state. Multiyear group policies need not comply until the expiration of their current multiyear term unless the policyholder elects to comply before that time.

2. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

3. The provisions of sections 376.825 to 376.836 shall expire on January 1, 2011.**]**

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