HOUSE _____ **AMENDMENT NO.**___

Offered By

_____ _____

AMEND House Committee Substitute for Senate Substitute for Senate Committee Substitute for Senate Bill No. 682, Page 2, Section 334.153, Line 32, by inserting after all of said section and line the following:

"376.1192. 1. As used in this section, "health benefit plan" and "health carrier" shall have the same meaning as such terms are defined in section 376.1350.

2. Beginning September 1, 2012, the oversight division of the joint committee on legislative research shall perform an actuarial analysis of the cost impact to health carriers, insureds with a health benefit plan, and other private and public payers if state mandates were enacted to provide health benefit plan coverage for the following:

(1) Orally administered anticancer medication that is used to kill or slow the growth of cancerous cells than what the plan requires for an intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health carrier administering the health benefit plan;

(2) Diagnosis and treatment of eating disorders that include anorexia nervosa, bulimia, binge eating, eating disorders nonspecified, and any other severe eating disorders contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The actuarial analysis shall assume the following are included in health benefit plan coverage:

(a) Residential treatment for eating disorders, if such treatment is medically necessary in accordance with the Practice Guidelines for the Treatment of Patients with Eating Disorders, as most recently published by the American Psychiatric Association; and

(b) Access to psychiatric and medical treatment that provides coverage for integrated care and treatments as prescribed by medical and psychiatric health care professionals, including but not limited to nutrition counseling, physical therapy, dietician services, medical monitoring, and psychiatric monitoring;

(3) Diagnosis and treatment of infertility, including but not limited to in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer. For purposes of this subdivision, "infertility" means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The actuarial analysis shall assume that included in health benefit plan coverage is coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer which shall be required only if:

(a) The covered individual has been unable to attain or sustain a successful pregnancy through reasonable less costly medically appropriate infertility treatments for which coverage is available under the policy, plan, or contract;

(b) The covered individual has not undergone four completed oocyte retrievals; except that if a live birth follows a completed oocyte retrieval, two or more completed oocyte retrievals shall be covered; and

(c) The procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecological guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

3. By December 31, 2012, the director of the oversight division of the joint committee on legislative research shall submit a report of the actuarial findings prescribed by this section to the speaker, the president pro tem, and the chairpersons of the House of Representatives Special Committee on Health Insurance and the Senate Small Business, Insurance and Industry Committee.

4. For the purposes of this section, the actuarial analysis of health benefit plan coverage shall assume that such coverage:

(1) Shall not be subject to any greater deductible or copayment than other health care services provided by the health benefit plan; and

(2) 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, short-term major medical policies of six months' or less duration, or any other supplemental policy.

5. The cost for each actuarial analysis shall not exceed thirty thousand dollars and the oversight division of the joint committee on legislative research may utilize any actuary contracted to perform services for the Missouri consolidated health care plan to perform the analysis required under this section.

6. The provisions of this section shall expire on December 31, 2012.

376.1226. 1. No contract between a health carrier or health benefit plan and a dentist for the provision of dental services under a dental plan shall require that the dentist provide dental services to insureds in the dental plan at a fee established by the health carrier or health benefit plan if such dental services are not covered services under the dental plan.

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

(1) "Covered services", dental services reimbursable by a health carrier or health benefit plan or third party administrator under an applicable dental plan, subject to such contractual limitations on benefits as may apply, including but not limited to deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums,

alternative benefit payments, or frequency limitations;

(2) "Dental plan", any policy or contract of insurance which provides for coverage of dental services;

(3) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(4) "Health carrier", the same meaning as such term is defined in section 376.1350.

376.1227. 1. No contract between a health carrier or health benefit plan and an optometrist for the provision of optometric services under a vision plan shall require that the optometrist provide optometric services to insureds in the vision plan at a fee established by the health carrier or health benefit plan if such optometric services are not covered services under the vision plan.

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

(1) "Covered services", services reimbursable by a health carrier or health benefit plan under an applicable vision plan, subject to such contractual limitations on benefits as may apply, including but not limited to deductibles, waiting periods, or frequency limitations;

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

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

(4) "Vision plan", any policy or contract of insurance which provides for coverage of vision care services.

Section 1. The board of trustees of the Missouri consolidated health care plan shall conduct an actuarial analysis and report to the general assembly, on or before December 31, 2012, of the feasibility of including the health plan sponsored by the department of transportation into the Missouri consolidated health care plan. The health plan sponsored by the department of transportation shall provide the Missouri consolidated health care plan actuary the data and funding necessary to perform the actuarial analysis.”; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.