

House _____ Amendment NO. _____

Offered By _____

1 AMEND House Committee Substitute for Senate Substitute for Senate Committee Substitute for
2 Senate Bill No. 826, Page 1, Section A, Line 3, by inserting immediately after said section and line
3 the following:
4

5 "191.671. 1. No other section of this act shall apply to any insurer, health services
6 corporation, or health maintenance organization licensed by the department of insurance, financial
7 institutions and professional registration which conducts HIV testing only for the purposes of
8 assessing a person's fitness for insurance coverage offered by such insurer, health services
9 corporation, or health maintenance corporation, except that nothing in this section shall be construed
10 to exempt any insurer, health services corporation or health maintenance organization in their
11 capacity as employers from the provisions of section 191.665 relating to employment practices.

12 2. Upon renewal of any individual or group insurance policy, subscriber contractor health
13 maintenance organization contract covering medical expenses, no insurer, health services
14 corporation or health maintenance organization shall deny or alter coverage to any previously
15 covered individual who has been diagnosed as having HIV infection or any HIV-related condition
16 during the previous policy or contract period only because of such diagnosis, nor shall any such
17 insurer, health services corporation or health maintenance organization exclude coverage for
18 treatment of such infection or condition with respect to any such individual. The provisions of this
19 subsection shall not apply to short-term major medical policies having a duration of less than one
20 year.

21 3. The director of the department of insurance, financial institutions and professional
22 registration shall establish by regulation standards for the use of HIV testing by insurers, health
23 services corporations and health maintenance organizations.

24 4. A laboratory certified by the U.S. Department of Health and Human Services under the
25 Clinical Laboratory Improvement Act of 1967, permitting testing of specimens obtained in interstate
26 commerce, and which subjects itself to ongoing proficiency testing by the College of American
27 Pathologists, the American Association of Bio Analysts, or an equivalent program approved by the
28 Centers for Disease Control shall be authorized to perform or conduct HIV testing for an insurer,
29 health services corporation or health maintenance organization pursuant to this section.

30 5. The result or results of HIV testing of an applicant for insurance coverage shall not be
31 disclosed by an insurer, health services corporation or health maintenance organization, except as
32 specifically authorized by such applicant in writing. Such result or results shall, however, be
33 disclosed to a physician designated by the subject of the test. If there is no physician designated, the
34 insurer, health services corporation, or health maintenance organization shall disclose the identity of
35 individuals residing in Missouri having a confirmed positive HIV test result to the department of
36 health and senior services. Provided, further, that no such insurer, health services corporation or

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health maintenance organization shall be liable for violating any duty or right of confidentiality established by law for disclosing such identity of individuals having a confirmed positive HIV test result to the department of health and senior services. Such disclosure shall be in a manner that ensures confidentiality. Disclosure of test results in violation of this section shall constitute a violation of sections 375.930 to 375.948 regulating trade practices in the business of insurance. Nothing in this subsection shall be construed to foreclose any remedies existing on June 1, 1988."; and

Further amend said bill, Page 11, Section 195.070, Lines 24-31, by deleting all of said lines and inserting in lieu thereof the following:

"patient, for any reason, if such practitioner did not originally dispense the drug, except as provided in section 195.265."; and

Further amend said bill, Page 12, Section 195.080, Line 24, by inserting after the words "treatment for cancer" the words "or sickle cell disease"; and

Further amend said bill, page, and section, Line 28, by inserting after the words "dispense medication" the words "in good faith"; and

Further amend said bill and page, Section 195.265, Line 1, by inserting immediately after the number "195.265." the following:

"1. Unused controlled substances may be accepted from ultimate users, from hospice or home health care providers on behalf of ultimate users to the extent federal law allows, or any person lawfully entitled to dispose of a decedent's property if the decedent was an ultimate user who died while in lawful possession of a controlled substance, through:

(1) Collection receptacles, drug disposal boxes, mail back packages, and other means by a Drug Enforcement Agency-authorized collector in accordance with federal regulations even if the authorized collector did not originally dispense the drug; or

(2) Drug take back programs conducted by federal, state, tribal, or local law enforcement agencies in partnership with any person or entity.

This subsection shall supersede and preempt any local ordinances or regulations, including any ordinances or regulations enacted by any political subdivision of the state, regarding the disposal of unused controlled substances. For the purposes of this section, the term "ultimate user" shall mean a person who has lawfully obtained and possesses a controlled substance for his or her own use or for the use of a member of his or her household or for an animal owned by him or her or a member of his or her household.

2."; and

Further amend said bill and section, Page 13, Line 7, by deleting the word "mailers" and inserting in lieu thereof the words "mail back packages"; and

Further amend said bill, page, and section, Line 12, by inserting immediately after the word "location" the phrase "and is updated every six months by the department"; and

Further amend said bill, page, and section, Line 13, by inserting immediately after the word

1 "events" the words "and mail back events"; and
 2

3 Further amend said bill, page, and section, Line 14, by inserting immediately after the word "event"
 4 the phrase "and is updated every six months by the department"; and
 5

6 Further amend said bill, page, and section, Line 16, by deleting the words "4 of section 195.070"
 7 and inserting in lieu thereof the words "1 of this section"; and
 8

9 Further amend said bill, page, and section, Line 18, by inserting after all of said section and line the
 10 following:
 11

12 "208.183. 1. There shall be established an "Advisory Council on Rare Diseases and
 13 Personalized Medicine" within the MO HealthNet division. The advisory council shall serve as an
 14 expert advisory committee to the drug utilization review board, providing necessary consultation to
 15 the board when the board makes recommendations or determinations regarding beneficiary access to
 16 drugs or biological products for rare diseases, or when the board itself determines that it lacks the
 17 specific scientific, medical, or technical expertise necessary for the proper performance of its
 18 responsibilities and such necessary expertise can be provided by experts outside the board.
 19 "Beneficiary access", as used in this section, shall mean developing prior authorization and
 20 reauthorization criteria for a rare disease drug, including placement on a preferred drug list or a
 21 formulary, as well as payment, cost-sharing, drug utilization review, or medication therapy
 22 management.

23 2. The advisory council on rare diseases and personalized medicine shall be composed of
 24 the following health care professionals, who shall be appointed by the director of the department of
 25 social services:

26 (1) Two physicians affiliated with a public school of medicine who are licensed and
 27 practicing in this state with experience researching, diagnosing, or treating rare diseases;

28 (2) Two physicians affiliated with private schools of medicine headquartered in this state
 29 who are licensed and practicing in this state with experience researching, diagnosing, or treating rare
 30 diseases;

31 (3) A physician who holds a doctor of osteopathy degree, who is active in medical practice,
 32 and who is affiliated with a school of medicine in this state with experience researching, diagnosing,
 33 or treating rare diseases;

34 (4) Two medical researchers from either academic research institutions or medical research
 35 organizations in this state who have received federal or foundation grant funding for rare disease
 36 research;

37 (5) A registered nurse or advanced practice registered nurse licensed and practicing in this
 38 state with experience treating rare diseases;

39 (6) A pharmacist practicing in a hospital in this state which has a designated orphan disease
 40 center;

41 (7) A professor employed by a pharmacy program in this state that is fully accredited by the
 42 Accreditation Council for Pharmacy Education and who has advanced scientific or medical training
 43 in orphan and rare disease treatments;

44 (8) One individual representing the rare disease community or who is living with a rare
 45 disease;

46 (9) One member who represents a rare disease foundation;

47 (10) A representative from a rare disease center located within one of the state's
 48 comprehensive pediatric hospitals;

1 (11) The chair of the joint committee on the life sciences or the chair's designee; and

2 (12) The chairperson of the drug utilization review board, or the chairperson's designee,
 3 who shall serve as an ex officio, nonvoting member of the advisory council.

4 3. The director shall convene the first meeting of the advisory council on rare diseases and
 5 personalized medicine no later than February 28, 2019. Following the first meeting, the advisory
 6 council shall meet upon the call of the chairperson of the drug utilization review board or upon the
 7 request of a majority of the council members.

8 4. The drug utilization review board, when making recommendations or determinations
 9 regarding beneficiary access to drugs and biological products for rare diseases, as defined in the
 10 federal Orphan Drug Act of 1983, P.L. 97-414, and drugs and biological products that are approved
 11 by the U.S. Food and Drug Administration and within the emerging fields of personalized medicine
 12 and noninheritable gene editing therapeutics, shall request and consider information from the
 13 advisory council on rare diseases and personalized medicine.

14 5. The drug utilization review board shall seek the input of the advisory council on rare
 15 diseases and personalized medicine to address topics for consultation under this section including,
 16 but not limited to:

17 (1) Rare diseases;

18 (2) The severity of rare diseases;

19 (3) The unmet medical need associated with rare diseases;

20 (4) The impact of particular coverage, cost-sharing, tiering, utilization management, prior
 21 authorization, medication therapy management, or other Medicaid policies on access to rare disease
 22 therapies;

23 (5) An assessment of the benefits and risks of therapies to treat rare diseases;

24 (6) The impact of particular coverage, cost-sharing, tiering, utilization management, prior
 25 authorization, medication therapy management, or other policies on patients' adherence to the
 26 treatment regimen prescribed or otherwise recommended by their physicians;

27 (7) Whether beneficiaries who need treatment from or a consultation with a rare disease
 28 specialist have adequate access and, if not, what factors are causing the limited access; and

29 (8) The demographics and the clinical description of patient populations.

30 6. Nothing in this section shall be construed to create a legal right for a consultation on any
 31 matter or to require the drug utilization review board to meet with any particular expert or
 32 stakeholder.

33 7. Recommendations of the advisory council on rare diseases and personalized medicine on
 34 an applicable treatment of a rare disease shall be explained in writing to members of the drug
 35 utilization review board during public hearings.

36 8. For purposes of this section, a "rare disease drug" shall mean a drug used to treat a rare
 37 medical condition, defined as any disease or condition that affects fewer than two hundred thousand
 38 persons in the United States, such as cystic fibrosis, hemophilia, and multiple myeloma.

39 9. All members of the advisory council on rare diseases and personalized medicine shall
 40 annually sign a conflict of interest statement revealing economic or other relationships with entities
 41 that could influence a member's decisions, and at least twenty percent of the advisory council
 42 members shall not have a conflict of interest with respect to any insurer, pharmaceutical benefits
 43 manager, or pharmaceutical manufacturer."; and

44
 45 Further amend said bill and page, Section 338.010, Line 9, by inserting immediately after the word
 46 "[twelve]" the words "at least"; and

47
 48 Further amend said bill, page, and section, Line 10, by inserting after the word "the" the phrase "age

recommended by the"; and

Further amend said bill, page, section, and line, by deleting the word "recommendations"; and

Further amend said bill and section, Page 14, Lines 47-48 and 53, by deleting each instance of the phrase "[and administration of viral influenza vaccines]" and inserting in lieu thereof "and administration of viral influenza vaccines"; and

Further amend said bill, Pages 16-17, Section 338.056, Lines 14-31, by deleting all of said lines and inserting in lieu thereof the following:

"2. A pharmacist who receives a prescription for a brand name drug or biological product may~~[-unless requested otherwise by the purchaser,]~~ select a less expensive generically equivalent or interchangeable biological product ~~[under the following circumstances:~~

~~—— (1) If a written prescription is involved, the prescription form used shall have two signature lines at opposite ends at the bottom of the form. Under the line at the right side shall be clearly printed the words: "Dispense as Written". Under the line at the left side shall be clearly printed the words "Substitution Permitted". The prescriber shall communicate the instructions to the pharmacist by signing the appropriate line] unless:~~

~~(1) the patient requests a brand name drug or biological product; or~~

~~(2) the prescribing practitioner indicates that substitution is prohibited or displays "brand medically necessary", "dispense as written", "do not substitute", "DAW", or words of similar import on the prescription.~~

~~3. No prescription shall be valid without the signature of the prescriber [on one of these lines;~~

~~—— (2)] .~~

4. If an oral prescription is involved, the practitioner or the practitioner's agent, communicating the instructions to the pharmacist, shall instruct the pharmacist as to whether or not a therapeutically equivalent generic drug or interchangeable biological product may be substituted. The pharmacist shall note the instructions on the file copy of the prescription."; and

Further amend said bill and section, Page 17, Line 38, by inserting immediately after all of said section and line the following:

"376.008. 1. All short-term major medical policies delivered or issued for delivery in this state shall include on any application for coverage and on the fact page of all policies a conspicuous and clearly captioned paragraph stating:

This policy may not cover preexisting conditions, including conditions you may currently have and are unaware of but are not diagnosed until the policy's term. This policy may not cover certain essential health benefits, including prescription drugs, preventative care, and emergency services. Before you realize benefits under this policy, you may be responsible for a deductible and/or coinsurance. Be sure to discuss these items with your insurance broker before purchasing a short-term medical policy.

2. No short-term major medical policy shall be delivered or issued for delivery in this state until the prospective insured has confirmed receipt of a benefit summary statement. As used in this section, "benefit summary statement" shall mean a no more than two-page plain language explanation of the following:

- 1 (1) Coverage limits, if any, expressed in dollars for:
 2 (a) Each occurrence;
 3 (b) Each covered benefit including, but not limited to, any benefit that is or was a covered
 4 benefit for any duration or dollar amount during the contract period and anything included under
 5 subdivision (2) of this subsection; and
 6 (c) Each contract period;
 7 (2) Copayments and deductibles for each covered benefit including, but not limited to:
 8 (a) Inpatient hospital care;
 9 (b) Outpatient hospital care;
 10 (c) Nonhospital inpatient care;
 11 (d) Nonhospital outpatient care;
 12 (e) Prescription drugs; and
 13 (f) Emergency services; and
 14 (3) Any copayment or deductible for an illness or affliction which differs from the
 15 copayment or deductible required to be described under subdivision (2) of this subsection.

16 376.385. 1. Each entity offering individual and group health insurance policies providing
 17 coverage on an expense-incurred basis, individual and group service or indemnity type contracts
 18 issued by a health services corporation, individual and group service contracts issued by a health
 19 maintenance organization, all self-insured group arrangements, to the extent not preempted by
 20 federal law, and all managed health care delivery entities of any type or description, that are
 21 delivered, issued for delivery, continued or renewed in this state on or after January 1, 1998, shall
 22 offer coverage for all physician-prescribed medically appropriate and necessary equipment, supplies
 23 and self-management training used in the management and treatment of diabetes. Coverage shall
 24 include persons with gestational, type I or type II diabetes. 2. Health care services required
 25 by this section shall not be subject to any greater deductible or co-payment than any other health
 26 care service provided by the policy, contract or plan.

27 3. No entity enumerated in subsection 1 of this section may reduce or eliminate coverage
 28 due to the requirements of this section.

29 4. Nothing in this section shall apply to accident-only, specified disease, hospital indemnity,
 30 Medicare supplement, long-term care, short-term major medical policies having a duration of less
 31 than one year, or other limited benefit health insurance policies.

32 376.429. 1. All health benefit plans, as defined in section 376.1350, that are delivered,
 33 issued for delivery, continued or renewed on or after August 28, 2006, and providing coverage to
 34 any resident of this state shall provide coverage for routine patient care costs as defined in
 35 subsection 7 of this section incurred as the result of phase II, III, or IV of a clinical trial that is
 36 approved by an entity listed in subsection 4 of this section and is undertaken for the purposes of the
 37 prevention, early detection, or treatment of cancer. Health benefit plans may limit coverage for the
 38 routine patient care costs of patients in phase II of a clinical trial to those treating facilities within
 39 the health benefit plans' provider network; except that, this provision shall not be construed as
 40 relieving a health benefit plan of the sufficiency of network requirements under state statute.

41 2. In the case of treatment under a clinical trial, the treating facility and personnel must have
 42 the expertise and training to provide the treatment and treat a sufficient volume of patients. There
 43 must be equal to or superior, noninvestigational treatment alternatives and the available clinical or
 44 preclinical data must provide a reasonable expectation that the treatment will be superior to the
 45 noninvestigational alternatives.

46 3. Coverage required by this section shall include coverage for routine patient care costs
 47 incurred for drugs and devices that have been approved for sale by the Food and Drug
 48 Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's

particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

4. Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to phase III or IV of clinical trials that are approved or funded by one of the following entities:

- (1) One of the National Institutes of Health (NIH);
- (2) An NIH cooperative group or center as defined in subsection 7 of this section;
- (3) The FDA in the form of an investigational new drug application;
- (4) The federal Departments of Veterans' Affairs or Defense;
- (5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or
- (6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

5. Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to phase II of clinical trials if:

- (1) Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
- (2) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

6. An entity seeking coverage for treatment, prevention, or early detection in a clinical trial approved by an institutional review board under subdivision (5) of subsection 4 of this section shall maintain and post electronically a list of the clinical trials meeting the requirements of subsections 2 and 3 of this section. This list shall include: the phase for which the clinical trial is approved; the entity approving the trial; the particular disease; and the number of participants in the trial. If the electronic posting is not practical, the entity seeking coverage shall periodically provide payers and providers in the state with a written list of trials providing the information required in this section.

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

- (1) "Cooperative group", a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
- (2) "Multiple project assurance contract", a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;
- (3) "Routine patient care costs" shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:
 - (a) The investigational item or service itself;
 - (b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
 - (c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

8. For the purpose of this section, providers participating in clinical trials shall obtain a patient's informed consent for participation on the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to the health insurer

1 upon request.

2 9. The provisions of this section shall not apply to a policy, plan or contract paid under Title
3 XVIII or Title XIX of the Social Security Act.

4 10. Nothing in this section shall apply to any accident-only policy, specified disease policy,
5 hospital indemnity policy, Medicare supplement policy, long-term care policy, short-term major
6 medical policy ~~[of six months or less duration]~~ having a duration of less than one year, or other
7 limited benefit health insurance policies.

8 11. The provisions of this section regarding phase II of a clinical trial shall not apply
9 automatically to an individually underwritten health benefit plan, but shall be an option to any such
10 plan.

11 376.446. 1. Health carriers shall permit individuals to learn the amount of cost-sharing,
12 including deductibles, copayments, and coinsurance, under the individual's health benefit plan or
13 coverage that the individual would be responsible for paying with respect to the furnishing of a
14 specific item or service by a participating provider in a timely manner upon the request of the
15 individual. At a minimum, such information shall be made available to such individual through an
16 internet website and such other means for individuals without access to the internet. As used in this
17 section, the terms "health carrier" and "health benefit plans" shall have the same meanings assigned
18 to them in section 376.1350.

19 2. Health carriers shall permit individuals to learn the amount of cost-sharing, including
20 deductibles, copayments, and coinsurance, under an individual's short-term major medical policy,
21 having a duration of less than one year, that the individual would be responsible for paying with
22 respect to the furnishing of a specific item or service by a participating provider in a timely manner
23 upon the request of the individual. At a minimum, such information shall be made available to such
24 individual through an internet website and such other means for individuals without access to the
25 internet.

26 ~~[2.]~~ 3. This section shall not apply to a supplemental insurance policy, including a life care
27 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
28 benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care
29 policy~~[, short-term major medical policy of six months or less duration]~~, or any other supplemental
30 policy.

31 ~~[-3.]~~ 4. The provisions of subsections 1 and 2 shall become effective on January 1, 2014.

32 376.452. 1. Except as provided in this section, if a health insurance issuer offers health
33 insurance coverage in the large group market in connection with a group health plan, the health
34 insurance issuer shall renew or continue the coverage in force at the option of the plan sponsor. The
35 provisions of this subsection shall not apply to short-term major medical policies having a duration
36 of less than one year.

37 2. A health insurance issuer may nonrenew or discontinue health insurance coverage offered
38 in connection with a group health plan in the large group market if:

39 (1) The plan sponsor has failed to pay premiums or contributions in accordance with the
40 terms of the health insurance coverage or if the health insurance issuer has not received timely
41 premium payments;

42 (2) The plan sponsor has performed an act or practice that constitutes fraud or has made an
43 intentional misrepresentation of material fact under the terms of the coverage;

44 (3) The plan sponsor has failed to comply with the health insurance issuer's minimum
45 participation requirements;

46 (4) The plan sponsor has failed to comply with the health insurance issuer's employer
47 contribution requirements;

48 (5) The health insurance issuer is ceasing to offer coverage in the large group market in

1 accordance with subsection 3 of this section;

2 (6) In the case of a health insurance issuer that offers health insurance coverage in the large
3 group market through a network plan, there is no longer any enrollee under the group health plan
4 who lives, resides, or works in the service area of the health insurance issuer or in the area for which
5 the issuer is authorized to do business;

6 (7) In the case of health insurance coverage that is made available in the large group market
7 only through one or more bona fide associations, the membership of an employer in the bona fide
8 association ceases, but only if coverage is terminated under this subdivision uniformly without
9 regard to any health status-related factor of any covered individual.

10 3. A health insurance issuer shall not discontinue offering a particular type of group health
11 insurance coverage offered in the large group market unless:

12 (1) The issuer provides notice to each plan sponsor, participant and beneficiary provided
13 coverage of this type in the large group market of the discontinuation at least ninety days prior to
14 the date of the discontinuation of the coverage;

15 (2) The issuer offers to each plan sponsor being provided coverage of this type in the large
16 group market the option to purchase any other health insurance coverage currently being offered by
17 the health insurance issuer to a group health plan in the large group market; and

18 (3) The issuer acts uniformly without regard to the claims experience of those plan sponsors
19 or any health status-related factor of any participant or beneficiary covered or new participant or
20 beneficiary who may become eligible for such coverage.

21 4. (1) A health insurance issuer shall not discontinue offering all health insurance coverage
22 in the large group market unless:

23 (a) The issuer provides notice of discontinuation to the director and to each plan sponsor,
24 participant and beneficiary covered at least one hundred eighty days prior to the date of the
25 discontinuation of coverage; and

26 (b) All health insurance issued or delivered for issuance in Missouri in the large group
27 market is discontinued and coverage under such health insurance is not renewed.

28 (2) In the case of a discontinuation under this subsection, the health insurance issuer shall
29 not provide for the issuance of any health insurance coverage in the large group market for a period
30 of five years beginning on the date of the discontinuation of the last health insurance coverage not
31 renewed.

32 5. At the time of coverage renewal, a health insurance issuer may modify the health
33 insurance coverage for a product offered to a group health plan in the large group market. For
34 purposes of this subsection, renewal shall be deemed to occur not more often than annually on the
35 anniversary of the effective date of the group health plan's health insurance coverage unless a longer
36 term is specified in the policy or contract.

37 6. In the case of health insurance coverage that is made available by a health insurance
38 issuer only through one or more bona fide associations, a reference to plan sponsor in this section is
39 deemed, with respect to coverage provided to an employer member of the association, to include a
40 reference to such employer.

41 376.454. 1. Except as provided in this section, a health insurance issuer that provides
42 individual health insurance coverage to an individual shall renew or continue in force such coverage
43 at the option of the individual. The provisions of this subsection shall not apply to short-term major
44 medical policies having a duration of less than one year.

45 2. A health insurance issuer may nonrenew or discontinue health insurance coverage of an
46 individual in the individual market based only on one or more of the following:

47 (1) The individual has failed to pay premiums or contributions in accordance with the terms
48 of the health insurance coverage or the issuer has not received timely premium payments;

1 (2) The individual has performed an act or practice that constitutes fraud or made an
2 intentional misrepresentation of material fact under the terms of the coverage;

3 (3) The issuer is ceasing to offer coverage in the individual market in accordance with
4 subsection 4 of this section;

5 (4) In the case of a health insurance issuer that offers health insurance coverage in the
6 market through a network plan, the individual no longer resides, lives, or works in the service area
7 or in an area for which the issuer is authorized to do business but only if such coverage is terminated
8 under this subdivision uniformly without regard to any health status-related factor of covered
9 individuals;

10 (5) In the case of health insurance coverage that is made available in the individual market
11 only through one or more bona fide associations, the membership of the individual in the
12 association on the basis of which the coverage is provided ceases, but only if such coverage is
13 terminated under this subdivision uniformly without regard to any health status-related factor of
14 covered individuals.

15 3. In any case in which an issuer decides to discontinue offering a particular type of health
16 insurance coverage offered in the individual market, coverage of such type may be discontinued by
17 the issuer only if:

18 (1) The issuer provides notice to each covered individual provided coverage of this type in
19 such market of such discontinuation at least ninety days prior to the date of the discontinuation of
20 such coverage;

21 (2) The issuer offers to each individual in the individual market provided coverage of this
22 type, the option to purchase any other individual health insurance coverage currently being offered
23 by the issuer for individuals in such market; and

24 (3) In exercising the option to discontinue coverage of this type and in offering the option of
25 coverage under subdivision (2) of this subsection, the issuer acts uniformly without regard to any
26 health status-related factor of enrolled individuals or individuals who may become eligible for such
27 coverage.

28 4. (1) In any case in which a health insurance issuer elects to discontinue offering all health
29 insurance coverage in the individual market in the state, health insurance coverage may be
30 discontinued by the issuer only if:

31 (a) The issuer provides notice to the director and to each individual of such discontinuation
32 at least one hundred eighty days prior to the date of the expiration of such coverage; and

33 (b) All health insurance issued or delivered for issuance in the state in such market is
34 discontinued and coverage under such health insurance coverage in such market is not renewed.

35 (2) In the case of a discontinuation under subdivision (1) of this subsection, the issuer shall
36 not provide for the issuance of any health insurance coverage in the individual market for a five-
37 year period beginning on the date of the discontinuation of the last health insurance coverage not so
38 renewed.

39 5. At the time of coverage renewal, a health insurance issuer may modify the health
40 insurance coverage for a policy form offered to individuals in the individual market so long as such
41 modification is consistent with applicable law and effective on a uniform basis among all
42 individuals with that policy form. For purposes of this subsection, renewal shall be deemed to occur
43 not more often than annually on the anniversary of the effective date of the individual's health
44 insurance coverage or as specified in the policy or contract.

45 6. In applying this section in the case of health insurance coverage that is made available by
46 a health insurance issuer in the individual market to individuals only through one or more
47 associations, a reference to an individual is deemed to include a reference to such an association of
48 which the individual is a member.

1 7. An insurer shall provide a certification of creditable coverage as required by Public Law
2 104-191 and regulations pursuant thereto.

3 376.779. 1. All health plans or policies that are individually underwritten or provide for
4 such coverage for specific individuals and the members of their families, which provide for hospital
5 treatment, shall provide coverage, while confined in a hospital or in a residential or nonresidential
6 facility certified by the department of mental health, for treatment of alcoholism on the same basis
7 as coverage for any other illness, except that coverage may be limited to thirty days in any policy or
8 contract benefit period. All Missouri individual contracts issued on or after January 1, 2005, shall
9 be subject to this section. Coverage required by this section shall be included in the policy or
10 contract and payment provided as for other coverage in the same policy or contract notwithstanding
11 any construction or relationship of interdependent contracts or plans affecting coverage and
12 payment of reimbursement prerequisites under the policy or contract.

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

29 3. The department of mental health may issue rules necessary to carry out the provisions of
30 this section. No rule or portion of a rule promulgated under the authority of this section shall
31 become effective unless it has been promulgated pursuant to the provisions of section 536.024. 4.
32 All substance abuse treatment programs in Missouri receiving funding from the Missouri
33 department of mental health must be certified by the department.

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

40 376.781. 1. All group health insurance policies providing coverage on an expense-incurred
41 basis, all group service or indemnity contracts issued by a not-for-profit health service corporation,
42 all self-insured group health benefit plans of any type or description, and all such health plans or
43 policies that are individually underwritten or provide for such coverage for specific individuals and
44 the members of their families as nongroup policies, which provide for hospital treatment, shall offer
45 coverage for the necessary care and treatment of loss or impairment of speech or hearing subject to
46 the same durational limits, dollar limits, deductibles and coinsurance factors as other covered
47 services in such policies or contracts. All Missouri group contracts issued or renewed on or after
48 December 31, 1984, shall be subject to this section. Notwithstanding any construction or

1 relationship of interdependent contracts or plans affecting coverage and payment of reimbursement
 2 prerequisites under the policy or contract, coverage required by this section shall be included in the
 3 policy or contract and payment provided as for other coverage in the same policy or contract.

4 2. The offer of benefits under subsection 1 of this section shall be in writing and may be
 5 rejected by the individual or group policyholder.

6 3. Nothing in this section shall prohibit the insurance company or not-for-profit health
 7 service corporation from including any coverage for loss or impairment of speech, language or
 8 hearing as standard coverage in their policies or contracts, but same shall not contain terms contrary
 9 to this section.

10 4. The phrase "loss or impairment of speech or hearing" shall include those communicative
 11 disorders generally treated by a speech pathologist, audiologist or speech/language pathologist
 12 licensed by the state board of healing arts or certified by the American Speech-Language and
 13 Hearing Association (ASHA), or both, and which fall within the scope of his or her license or
 14 certification.

15 5. Any provision in a health insurance policy contrary to or in conflict with the provisions
 16 of this section shall, to the extent of the conflict, be void, but such invalidity shall not offset the
 17 validity of the other provisions of such policy.

18 6. The department of insurance, financial institutions and professional registration may issue
 19 rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated
 20 under the authority of this section shall become effective unless it has been promulgated pursuant to
 21 the provisions of section 536.024.

22 7. This section shall not apply to short-term major medical policies having a duration of less
 23 than one year.

24 376.782. 1. As used in this section, the term "low-dose mammography screening" means
 25 the X-ray examination of the breast using equipment specifically designed and dedicated for
 26 mammography, including the X-ray tube, filter, compression device, films, and cassettes, with an
 27 average radiation exposure delivery of less than one rad mid-breast, with two views for each breast,
 28 and any fee charged by a radiologist or other physician for reading, interpreting or diagnosing based
 29 on such X-ray.

30 2. All individual and group health insurance policies providing coverage on an expense-
 31 incurred basis, individual and group service or indemnity type contracts issued by a nonprofit
 32 corporation, individual and group service contracts issued by a health maintenance organization, all
 33 self-insured group arrangements to the extent not preempted by federal law and all managed health
 34 care delivery entities of any type or description, that are delivered, issued for delivery, continued or
 35 renewed on or after August 28, 1991, and providing coverage to any resident of this state shall
 36 provide benefits or coverage for low-dose mammography screening for any nonsymptomatic
 37 woman covered under such policy or contract which meets the minimum requirements of this
 38 section. Such benefits or coverage shall include at least the following:

- 39 (1) A baseline mammogram for women age thirty-five to thirty-nine, inclusive;
- 40 (2) A mammogram for women age forty to forty-nine, inclusive, every two years or more
 41 frequently based on the recommendation of the patient's physician;
- 42 (3) A mammogram every year for women age fifty and over;
- 43 (4) A mammogram for any woman, upon the recommendation of a physician, where such
 44 woman, her mother or her sister has a prior history of breast cancer.

45 3. Coverage and benefits related to mammography as required by this section shall be at
 46 least as favorable and subject to the same dollar limits, deductibles, and co-payments as other
 47 radiological examinations.

48 4. The provisions of this section shall not apply to short-term major medical policies having

1 a duration of less than one year.

2 376.811. 1. Every insurance company and health services corporation doing business in this
3 state shall offer in all health insurance policies benefits or coverage for chemical dependency
4 meeting the following minimum standards:

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

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

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

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

17 (5) The coverages set forth in this subsection:

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

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

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

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

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

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

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

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

42 (5) The coverages set forth in this subsection may be administered pursuant to a managed
43 care program established by the insurance company, health services corporation or health
44 maintenance organization, and covered services may be delivered through a system of contractual
45 arrangements with one or more providers, community mental health centers, hospitals,
46 nonresidential or residential treatment programs, or other mental health service delivery entities
47 certified by the department of mental health, or accredited by a nationally recognized organization,
48 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, licensed clinical social worker, or, subject to contractual provisions, a licensed marital and family therapist, 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]~~ having a duration of less than one year, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.845. 1. For the purposes of this section the following terms shall mean:

(1) "Eating disorder", pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding or eating disorder, and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association where diagnosed by a licensed physician, psychiatrist, psychologist, clinical social worker, licensed marital and family therapist, or professional counselor duly licensed in the state where he or she practices and acting within their applicable scope of practice in the state where he or she practices;

(2) "Health benefit plan", shall have the same meaning as such term is defined in section 376.1350; however, for purposes of this section "health benefit plan" does not include 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 policy ~~[of six months or less duration]~~ having a duration of less than one year, or any other supplemental policy;

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

(4) "Medical care", health care services needed to diagnose, prevent, treat, cure, or relieve physical manifestations of an eating disorder, and shall include inpatient hospitalization, partial

hospitalization, residential care, intensive outpatient treatment, follow-up outpatient care, and counseling;

(5) "Pharmacy care", medications prescribed by a licensed physician for an eating disorder and includes any health-related services deemed medically necessary to determine the need or effectiveness of the medications, but only to the extent that such medications are included in the insured's health benefit plan;

(6) "Psychiatric care" and "psychological care", direct or consultative services provided during inpatient hospitalization, partial hospitalization, residential care, intensive outpatient treatment, follow-up outpatient care, and counseling provided by a psychiatrist or psychologist licensed in the state of practice;

(7) "Therapy", medical care and behavioral interventions provided by a duly licensed physician, psychiatrist, psychologist, professional counselor, licensed clinical social worker, or family marriage therapist where said person is licensed or registered in the states where he or she practices;

(8) "Treatment of eating disorders", therapy provided by a licensed treating physician, psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed physician's, psychiatrist's, psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license in the state where he or she practices for an individual diagnosed with an eating disorder.

2. In accordance with the provisions of section 376.1550, all health benefit plans that are delivered, issued for delivery, continued or renewed on or after January 1, 2017, if written inside the state of Missouri, or written outside the state of Missouri but covering Missouri residents, shall provide coverage for the diagnosis and treatment of eating disorders as required in section 376.1550.

3. Coverage provided under this section is limited to medically necessary treatment that is provided by a licensed treating physician, psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed physician's, psychiatrist's, psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license and acting within their applicable scope of coverage, in accordance with a treatment plan.

4. The treatment plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

5. Coverage of the treatment of eating disorders may be subject to other general exclusions and limitations of the contract or benefit plan not in conflict with the provisions of this section, such as coordination of benefits, and utilization review of health care services, which includes reviews of medical necessity and care management. Medical necessity determinations and care management for the treatment of eating disorders shall consider the overall medical and mental health needs of the individual with an eating disorder, shall not be based solely on weight, and shall take into consideration the most recent Practice Guideline for the Treatment of Patients with Eating Disorders adopted by the American Psychiatric Association in addition to current standards based upon the medical literature generally recognized as authoritative in the medical community.

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, 2013, 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

1 health benefit plan, and other private and public payers if state mandates were enacted to provide
 2 health benefit plan coverage for the following:

3 (1) Orally administered anticancer medication that is used to kill or slow the growth of
 4 cancerous cells charged at the same co-payment, deductible, or coinsurance amount as intravenously
 5 administered or injected cancer medication that is provided, regardless of formulation or benefit
 6 category determination by the health carrier administering the health benefit plan;

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

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

15 (b) Access to medical treatment that provides coverage for integrated care and treatment as
 16 recommended by medical and mental health care professionals, including but not limited to
 17 psychological services, nutrition counseling, physical therapy, dietician services, medical
 18 monitoring, and psychiatric monitoring.

19 3. By December 31, 2013, the director of the oversight division of the joint committee on
 20 legislative research shall submit a report of the actuarial findings prescribed by this section to the
 21 speaker of the house of representatives, the president pro tempore of the senate, and the
 22 chairpersons of the house of representatives committee on health insurance and the senate small
 23 business, insurance and industry committee, or the committees having jurisdiction over health
 24 insurance issues if the preceding committees no longer exist.

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

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

29 (2) Shall not apply to a supplemental insurance policy, including a life care contract,
 30 accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only,
 31 Medicare supplement policy, long-term care policy, short-term major medical policies [~~of six~~
 32 ~~months' or less duration~~] having a duration of less than one year, or any other supplemental policy.

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

37 6. The provisions of this section shall expire on December 31, 2013.

38 376.1199. 1. Each health carrier or health benefit plan that offers or issues health benefit
 39 plans providing obstetrical/gynecological benefits and pharmaceutical coverage, which are
 40 delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002, shall:

41 (1) Notwithstanding the provisions of subsection 4 of section 354.618, provide enrollees
 42 with direct access to the services of a participating obstetrician, participating gynecologist or
 43 participating obstetrician/gynecologist of her choice within the provider network for covered
 44 services. The services covered by this subdivision shall be limited to those services defined by the
 45 published recommendations of the accreditation council for graduate medical education for training
 46 an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to diagnosis,
 47 treatment and referral for such services. A health carrier shall not impose additional co-payments,
 48 coinsurance or deductibles upon any enrollee who seeks or receives health care services pursuant to

1 this subdivision, unless similar additional co-payments, coinsurance or deductibles are imposed for
 2 other types of health care services received within the provider network. Nothing in this subsection
 3 shall be construed to require a health carrier to perform, induce, pay for, reimburse, guarantee,
 4 arrange, provide any resources for or refer a patient for an abortion, as defined in section 188.015,
 5 other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is
 6 performed, or to supersede or conflict with section 376.805; and

7 (2) Notify enrollees annually of cancer screenings covered by the enrollees' health benefit
 8 plan and the current American Cancer Society guidelines for all cancer screenings or notify
 9 enrollees at intervals consistent with current American Cancer Society guidelines of cancer
 10 screenings which are covered by the enrollees' health benefit plans. The notice shall be delivered by
 11 mail unless the enrollee and health carrier have agreed on another method of notification; and

12 (3) Include coverage for services related to diagnosis, treatment and appropriate
 13 management of osteoporosis when such services are provided by a person licensed to practice
 14 medicine and surgery in this state, for individuals with a condition or medical history for which
 15 bone mass measurement is medically indicated for such individual. In determining whether testing
 16 or treatment is medically appropriate, due consideration shall be given to peer-reviewed medical
 17 literature. A policy, provision, contract, plan or agreement may apply to such services the same
 18 deductibles, coinsurance and other limitations as apply to other covered services; and

19 (4) If the health benefit plan also provides coverage for pharmaceutical benefits, provide
 20 coverage for contraceptives either at no charge or at the same level of deductible, coinsurance or co-
 21 payment as any other covered drug.

22 No such deductible, coinsurance or co-payment shall be greater than any drug on the health benefit
 23 plan's formulary. As used in this section, "contraceptive" shall include all prescription drugs and
 24 devices approved by the federal Food and Drug Administration for use as a contraceptive, but shall
 25 exclude all drugs and devices that are intended to induce an abortion, as defined in section 188.015,
 26 which shall be subject to section 376.805. Nothing in this subdivision shall be construed to exclude
 27 coverage for prescription contraceptive drugs or devices ordered by a health care provider with
 28 prescriptive authority for reasons other than contraceptive or abortion purposes.

29 2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the
 30 same meaning as defined in section 376.1350.

31 3. The provisions of this section shall not apply to a supplemental insurance policy,
 32 including a life care contract, accident-only policy, specified disease policy, hospital policy
 33 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term
 34 major medical policy [~~of six months or less duration~~] having a duration of less than one year, or any
 35 other supplemental policy as determined by the director of the department of insurance, financial
 36 institutions and professional registration.

37 4. Notwithstanding the provisions of subdivision (4) of subsection 1 of this section to the
 38 contrary:

39 (1) Any health carrier shall offer and issue to any person or entity purchasing a health
 40 benefit plan, a health benefit plan that excludes coverage for contraceptives if the use or provision
 41 of such contraceptives is contrary to the moral, ethical or religious beliefs or tenets of such person
 42 or entity;

43 (2) Upon request of an enrollee who is a member of a group health benefit plan and who
 44 states that the use or provision of contraceptives is contrary to his or her moral, ethical or religious
 45 beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that excludes
 46 coverage for contraceptives. Any administrative costs to a group health benefit plan associated with
 47 such exclusion of coverage not offset by the decreased costs of providing coverage shall be borne by
 48 the group policyholder or group plan holder;

(3) Any health carrier which is owned, operated or controlled in substantial part by an entity that is operated pursuant to moral, ethical or religious tenets that are contrary to the use or provision of contraceptives shall be exempt from the provisions of subdivision (4) of subsection 1 of this section. For purposes of this subsection, if new premiums are charged for a contract, plan or policy, it shall be determined to be a new contract, plan or policy.

5. Except for a health carrier that is exempted from providing coverage for contraceptives pursuant to this section, a health carrier shall allow enrollees in a health benefit plan that excludes coverage for contraceptives pursuant to subsection 4 of this section to purchase a health benefit plan that includes coverage for contraceptives.

6. Any health benefit plan issued pursuant to subsection 1 of this section shall provide clear and conspicuous written notice on the enrollment form or any accompanying materials to the enrollment form and the group health benefit plan application and contract:

(1) Whether coverage for contraceptives is or is not included;

(2) That an enrollee who is a member of a group health benefit plan with coverage for contraceptives has the right to exclude coverage for contraceptives if such coverage is contrary to his or her moral, ethical or religious beliefs;

(3) That an enrollee who is a member of a group health benefit plan without coverage for contraceptives has the right to purchase coverage for contraceptives;

(4) Whether an optional rider for elective abortions has been purchased by the group contract holder pursuant to section 376.805; and

(5) That an enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs.

For purposes of this subsection, if new premiums are charged for a contract, plan, or policy, it shall be determined to be a new contract, plan, or policy.

7. Health carriers shall not disclose to the person or entity who purchased the health benefit plan the names of enrollees who exclude coverage for contraceptives in the health benefit plan or who purchase a health benefit plan that includes coverage for contraceptives. Health carriers and the person or entity who purchased the health benefit plan shall not discriminate against an enrollee because the enrollee excluded coverage for contraceptives in the health benefit plan or purchased a health benefit plan that includes coverage for contraceptives.

8. The departments of health and senior services and insurance, financial institutions and professional registration may promulgate rules necessary to implement the provisions of this section. No rule or portion of a rule promulgated pursuant to this section shall become effective unless it has been promulgated pursuant to chapter 536. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2001, shall be invalid and void.

376.1200. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1996, shall

offer coverage for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants. The offer of benefits under this section shall be in writing and must be accepted in writing by the individual or group policyholder or contract holder.

2. Such health care service shall not be subject to any greater deductible or co-payment than any other health care service provided by the policy, contract or plan, except that the policy, contract or plan may contain a provision imposing a lifetime benefit maximum of not less than one hundred thousand dollars, for dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for breast cancer treatment.

3. Benefits may be administered for such health care service through a managed care program of exclusive and/or preferred contractual arrangements with one or more providers rendering such health care service. These contractual arrangements may provide that the provider shall hold the patient harmless for the cost of rendering such health care service if it is subsequently found by the entity authorized to resolve disputes that:

(1) Such care did not qualify under the protocols established for the providing of care for such health care service;

(2) Such care was not medically appropriate; or

(3) The provider otherwise failed to comply with the utilization management or other managed care provision agreed to in any contract between the entity and the provider.

4. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies ~~[of not more than seven months duration]~~ having a duration of less than one year.

5. Nothing in this section shall prohibit an entity from including all or part of such health care services as standard coverage in its policies, contracts or plans.

376.1209. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law, and all managed health care delivery entities of any type or description, that provide coverage for the surgical procedure known as a mastectomy, and which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1998, shall provide coverage for prosthetic devices or reconstructive surgery necessary to restore symmetry as recommended by the oncologist or primary care physician for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the same deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits with the exception that no time limit shall be imposed on an individual for the receipt of prosthetic devices or reconstructive surgery and if such individual changes his or her insurer, then the new policy subject to the federal Women's Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277), as amended, shall provide coverage consistent with the federal Women's Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277), as amended, and any regulations promulgated pursuant to such act.

2. As used in this section, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a physician licensed pursuant to chapter 334.

3. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy

1 providing a fixed daily benefit only, Medicare supplement policy, short-term major medical policy
 2 having a duration of less than one year, or long-term care policy.

3 376.1210. 1. Each entity offering individual and group health insurance policies providing
 4 coverage on an expense-incurred basis, individual and group service or indemnity type contracts
 5 issued by a nonprofit corporation, individual and group service contracts issued by a health
 6 maintenance organization, all self-insured group arrangements to the extent not preempted by
 7 federal law, and all managed health care delivery entities of any type or description, that are
 8 delivered, issued for delivery, continued or renewed in this state on or after January 1, 1997, and
 9 providing for maternity benefits, shall provide coverage for a minimum of forty-eight hours of
 10 inpatient care following a vaginal delivery and a minimum of ninety-six hours of inpatient care
 11 following a cesarean section for a mother and her newly born child in a hospital as defined in
 12 section 197.020 or any other health care facility licensed to provide obstetrical care under the
 13 provisions of chapter 197.

14 2. Notwithstanding the provisions of subsection 1 of this section, any entity offering
 15 individual and group health insurance policies providing coverage on an expense-incurred basis,
 16 individual and group service or indemnity type contracts issued by a nonprofit corporation,
 17 individual and group service contracts issued by a health maintenance organization, all self-insured
 18 group arrangements to the extent not preempted by federal law, and all managed health care
 19 delivery entities of any type or description that are delivered, issued for delivery, continued or
 20 renewed in this state on or after January 1, 1997, and providing for maternity benefits, may
 21 authorize a shorter length of hospital stay for services related to maternity and newborn care if:

22 (1) A shorter hospital stay meets with the approval of the attending physician after
 23 consulting with the mother. The physician's approval to discharge shall be made in accordance with
 24 the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy
 25 of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines
 26 prepared by another nationally recognized medical organization; and

27 (2) The entity providing the individual or group health insurance policy provides coverage
 28 for post-discharge care to the mother and her newborn.

29 3. Post-discharge care shall consist of a minimum of two visits at least one of which shall be
 30 in the home, in accordance with accepted maternal and neonatal physical assessments, by a
 31 registered professional nurse with experience in maternal and child health nursing or a physician.
 32 The location and schedule of the post-discharge visits shall be determined by the attending
 33 physician. Services provided by the registered professional nurse or physician shall include, but not
 34 be limited to, physical assessment of the newborn and mother, parent education, assistance and
 35 training in breast or bottle feeding, education and services for complete childhood immunizations,
 36 the performance of any necessary and appropriate clinical tests and submission of a metabolic
 37 specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical
 38 criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the
 39 American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or
 40 similar guidelines prepared by another nationally recognized medical organization. Any
 41 abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to
 42 the attending physician as medically appropriate.

43 4. For the purposes of this section, "attending physician" shall include the attending
 44 obstetrician, pediatrician, or other physician attending the mother or newly born child.

45 5. Each entity offering individual and group health insurance policies providing coverage on
 46 an expense-incurred basis, individual and group service or indemnity type contracts issued by a
 47 nonprofit corporation, individual and group service contracts issued by a health maintenance
 48 organization, all self-insured group arrangements to the extent not preempted by federal law and all

1 managed health care delivery entities of any type or description shall provide notice to
 2 policyholders, insured persons and participants regarding the coverage required by this section.
 3 Such notice shall be in writing and prominently positioned in the policy, certificate of coverage or
 4 summary plan description.

5 6. Such health care service shall not be subject to any greater deductible or co-payment than
 6 other similar health care services provided by the policy, contract or plan.

7 7. No insurer may provide financial disincentives to, or deselect, terminate the services of,
 8 require additional documentation from, require additional utilization review, or reduce payments to,
 9 or otherwise penalize the attending physician in retaliation solely for ordering care consistent with
 10 the provisions of this section.

11 8. The provisions of this section shall not apply to short-term major medical policies having
 12 a duration of less than one year.

13 9. The department of insurance, financial institutions and professional registration shall
 14 adopt rules and regulations to implement and enforce the provisions of this section. No rule or
 15 portion of a rule promulgated pursuant to this section shall become effective unless it has been
 16 promulgated pursuant to the provisions of section 536.024.

17 376.1215. 1. All individual and group health insurance policies providing coverage on an
 18 expense-incurred basis, individual and group service or indemnity type contracts issued by a health
 19 services corporation, individual and group service contracts issued by a health maintenance
 20 organization and all self-insured group arrangements to the extent not preempted by federal law and
 21 all managed health care delivery entities of any type or description shall provide coverage for
 22 immunizations of a child from birth to five years of age as provided by department of health and
 23 senior services regulations.

24 2. Such coverage shall not be subject to any deductible or co-payment limits.

25 3. The contract issued by a health maintenance organization may provide that the benefits
 26 required pursuant to this section shall be covered benefits only if the services are rendered by a
 27 provider who is designated by and affiliated with the health maintenance organization, except that
 28 the health maintenance organization shall, as a condition of participation, comply with the
 29 immunization requirements of state or federally funded health programs.

30 4. This section shall not apply to supplemental insurance policies, including life care
 31 contracts, accident-only policies, specified disease policies, hospital policies providing a fixed daily
 32 benefit only, Medicare supplement policies, long-term care policies, coverage issued as a
 33 supplement to liability insurance, short-term major medical policies [~~of six months or less duration~~]
 34 having a duration of less than one year, and other supplemental policies as determined by the
 35 department of insurance, financial institutions and professional registration. 5. The
 36 department of health and senior services shall promulgate rules and regulations to determine which
 37 immunizations shall be covered by policies, plans or contracts described in this section. No rule or
 38 portion of a rule promulgated under the authority of this section shall become effective unless it has
 39 been promulgated pursuant to the provisions of section 536.024. 6. No health care provider shall
 40 charge more than one hundred percent of the reasonable and customary charges for providing any
 41 immunization.

42 376.1218. 1. Any health carrier or health benefit plan that offers or issues health benefit
 43 plans, other than Medicaid health benefit plans, which are delivered, issued for delivery, continued,
 44 or renewed in this state on or after January 1, 2006, shall provide coverage for early intervention
 45 services described in this section that are delivered by early intervention specialists who are health
 46 care professionals licensed by the state of Missouri and acting within the scope of their professions
 47 for children from birth to age three identified by the Part C early intervention system as eligible for
 48 services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et

1 seq. Such coverage shall be limited to three thousand dollars for each covered child per policy per
2 calendar year, with a maximum of nine thousand dollars per child.

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

5 3. In the event that any health benefit plan is found not to be required to provide coverage
6 under subsection 1 of this section because of preemption by a federal law, including but not limited
7 to the act commonly known as ERISA contained in Title 29 of the United States Code, or in the
8 event that subsection 1 of this section is found to be unconstitutional, then the lead agency shall be
9 responsible for payment and provision of any benefit provided under this section.

10 4. For purposes of this section, "early intervention services" means medically necessary
11 speech and language therapy, occupational therapy, physical therapy, and assistive technology
12 devices for children from birth to age three who are identified by the Part C early intervention
13 system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20
14 U.S.C. Section 1431, et seq. Early intervention services shall include services under an active
15 individualized family service plan that enhance functional ability without effecting a cure. An
16 individualized family service plan is a written plan for providing early intervention services to an
17 eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section 1436. The
18 Part C early intervention system, on behalf of its contracted regional Part C early intervention
19 system centers and providers, shall be considered the rendering provider of services for purposes of
20 this section.

21 5. No payment made for specified early intervention services shall be applied by the health
22 carrier or health benefit plan against any maximum lifetime aggregate specified in the policy or
23 health benefit plan if the carrier opts to satisfy its obligations under this section under subdivision
24 (2) of subsection 7 of this section. A health benefit plan shall be billed at the applicable Medicaid
25 rate at the time the covered benefit is delivered, and the health benefit plan shall pay the Part C early
26 intervention system at such rate for benefits covered by this section. Services under the Part C early
27 intervention system shall be delivered as prescribed by the individualized family service plan and an
28 electronic claim filed in accordance with the carrier's or plan's standard format. Beginning January
29 1, 2007, such claims' payments shall be made in accordance with the provisions of sections 376.383
30 and 376.384.

31 6. The health care service required by this section shall not be subject to any greater
32 deductible, co-payment, or coinsurance than other similar health care services provided by the
33 health benefit plan.

34 7. (1) Subject to the provisions of this section, payments made during a calendar year by a
35 health carrier or group of carriers affiliated by or under common ownership or control to the Part C
36 early intervention system for services provided to children covered by the Part C early intervention
37 system shall not exceed one-half of one percent of the direct written premium for health benefit
38 plans as reported to the department of insurance, financial institutions and professional registration
39 on the health carrier's most recently filed annual financial statement.

40 (2) In lieu of reimbursing claims under this section, a carrier or group of carriers affiliated
41 by or under common ownership or control may, on behalf of all of the carrier's or carriers' health
42 benefit plan or plans providing coverage under this section, directly pay the Part C early
43 intervention system by January thirty-first of the calendar year an amount equal to one-half of one
44 percent of the direct written premium for health benefit plans as reported to the department of
45 insurance, financial institutions and professional registration on the health carrier's most recently
46 filed annual financial statement, or five hundred thousand dollars, whichever is less, and such
47 payment shall constitute full and complete satisfaction of the health benefit plan's obligation for the
48 calendar year. Nothing in this subsection shall require a health carrier or health benefit plan

1 providing coverage under this section to amend or modify any provision of an existing policy or
 2 plan relating to the payment or reimbursement of claims by the health carrier or health benefit plan.

3 8. This section shall not apply to a supplemental insurance policy, including a life care
 4 contract, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare
 5 supplement policy, hospitalization-surgical care policy, policy that is individually underwritten or
 6 provides such coverage for specific individuals and members of their families, long-term care
 7 policy, or short-term major medical policies ~~[of six months or less duration]~~ having a duration of
 8 less than one year.

9 9. Except for health carriers or health benefit plans making payments under subdivision (2)
 10 of subsection 7 of this section, the department of insurance, financial institutions and professional
 11 registration shall collect data related to the number of children receiving private insurance coverage
 12 under this section and the total amount of moneys paid on behalf of such children by private health
 13 carriers or health benefit plans. The department shall report to the general assembly regarding the
 14 department's findings no later than January 30, 2007, and annually thereafter.

15 10. Notwithstanding the provisions of section 23.253 to the contrary, the provisions of this
 16 section shall not sunset.

17 376.1219. 1. Each policy issued by an entity offering individual and group health insurance
 18 which provides coverage on an expense-incurred basis, individual and group health service or
 19 indemnity type contracts issued by a nonprofit corporation, individual and group service contracts
 20 issued by a health maintenance organization, all self-insured group health arrangements to the extent
 21 not preempted by federal law, and all health care plans provided by managed health care delivery
 22 entities of any type or description, that are delivered, issued for delivery, continued or renewed in
 23 this state on or after September 1, 1997, shall provide coverage for formula and low protein
 24 modified food products recommended by a physician for the treatment of a patient with
 25 phenylketonuria or any inherited disease of amino and organic acids who is covered under the
 26 policy, contract, or plan and who is less than six years of age.

27 2. For purposes of this section, "low protein modified food products" means foods that are
 28 specifically formulated to have less than one gram of protein per serving and are intended to be used
 29 under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low
 30 protein modified food products do not include foods that are naturally low in protein.

31 3. The coverage required by this section may be subject to the same deductible for similar
 32 health care services provided by the policy, contract, or plan as well as a reasonable coinsurance or
 33 co-payment on the part of the insured, which shall not be greater than fifty percent of the cost of the
 34 formula and food products, and may be subject to an annual benefit maximum of not less than five
 35 thousand dollars per covered child. Nothing in this section shall prohibit a carrier from using
 36 individual case management or from contracting with vendors of the formula and food products.

37 4. This section shall not apply to a supplemental insurance policy, including a life care
 38 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
 39 benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy
 40 having a duration of less than one year, or any other supplemental policy as determined by the
 41 director of the department of insurance, financial institutions and professional registration.

42 376.1220. 1. Each policy issued by an entity offering individual and group health insurance
 43 which provides coverage on an expense-incurred basis, individual or group health service, or
 44 indemnity contracts issued by a nonprofit corporation, individual and group service contracts issued
 45 by a health maintenance organization, all self-insured group health arrangements to the extent not
 46 preempted by federal law, and all health care plans provided by managed health care delivery
 47 entities of any type or description that are delivered, issued for delivery, continued or renewed in
 48 this state shall provide coverage for newborn hearing screening, necessary rescreening, audiological

1 assessment and follow-up, and initial amplification.

2 2. The health care service required by this section shall not be subject to any greater
3 deductible or co-payment than other similar health care services provided by the policy, contract or
4 plan.

5 3. This section shall not apply to a supplemental insurance policy, including a life care
6 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
7 benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies
8 ~~[of six months or less duration]~~ having a duration of less than one year, or any other supplemental
9 policy as determined by the director of the department of insurance, financial institutions and
10 professional registration.

11 4. Coverage for newborn hearing screening and any necessary rescreening and audiological
12 assessment shall be provided to newborns eligible for medical assistance pursuant to section
13 208.151, and the children's health program pursuant to sections 208.631 to 208.660, with payment
14 for the newborn hearing screening required in section 191.925, and any necessary rescreening,
15 audiological assessment and follow-up, and amplification as described in section 191.928.

16 376.1224. 1. For purposes of this section, the following terms shall mean:

17 (1) "Applied behavior analysis", the design, implementation, and evaluation of
18 environmental modifications, using behavioral stimuli and consequences, to produce socially
19 significant improvement in human behavior, including the use of direct observation, measurement,
20 and functional analysis of the relationships between environment and behavior;

21 (2) "Autism service provider":

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

24 (b) Any person who is licensed under chapter 337 as a board-certified behavior analyst by
25 the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified
26 behavior analyst;

27 (3) "Autism spectrum disorders", a neurobiological disorder, an illness of the nervous
28 system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder
29 Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the
30 most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American
31 Psychiatric Association;

32 (4) "Diagnosis of autism spectrum disorders", medically necessary assessments, evaluations,
33 or tests in order to diagnose whether an individual has an autism spectrum disorder;

34 (5) "Habilitative or rehabilitative care", professional, counseling, and guidance services and
35 treatment programs, including applied behavior analysis, that are necessary to develop the
36 functioning of an individual;

37 (6) "Health benefit plan", shall have the same meaning ascribed to it as in section 376.1350;

38 (7) "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;

39 (8) "Line therapist", an individual who provides supervision of an individual diagnosed with
40 an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment
41 plan, and implements specific behavioral interventions as outlined in the behavior plan under the
42 direct supervision of a licensed behavior analyst;

43 (9) "Pharmacy care", medications used to address symptoms of an autism spectrum disorder
44 prescribed by a licensed physician, and any health-related services deemed medically necessary to
45 determine the need or effectiveness of the medications only to the extent that such medications are
46 included in the insured's health benefit plan;

47 (10) "Psychiatric care", direct or consultative services provided by a psychiatrist licensed in
48 the state in which the psychiatrist practices;

1 (11) "Psychological care", direct or consultative services provided by a psychologist
 2 licensed in the state in which the psychologist practices;

3 (12) "Therapeutic care", services provided by licensed speech therapists, occupational
 4 therapists, or physical therapists;

5 (13) "Treatment for autism spectrum disorders", care prescribed or ordered for an individual
 6 diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist,
 7 including equipment medically necessary for such care, pursuant to the powers granted under such
 8 licensed physician's or licensed psychologist's license, including, but not limited to:

9 (a) Psychiatric care;

10 (b) Psychological care;

11 (c) Habilitative or rehabilitative care, including applied behavior analysis therapy;

12 (d) Therapeutic care;

13 (e) Pharmacy care.

14 2. All group health benefit plans that are delivered, issued for delivery, continued, or
 15 renewed on or after January 1, 2011, if written inside the state of Missouri, or written outside the
 16 state of Missouri but insuring Missouri residents, shall provide coverage for the diagnosis and
 17 treatment of autism spectrum disorders to the extent that such diagnosis and treatment is not already
 18 covered by the health benefit plan.

19 3. With regards to a health benefit plan, a health carrier shall not deny or refuse to issue
 20 coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate
 21 or restrict coverage on an individual or their dependent because the individual is diagnosed with
 22 autism spectrum disorder.

23 4. (1) Coverage provided under this section is limited to medically necessary treatment that
 24 is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to the
 25 powers granted under such licensed physician's or licensed psychologist's license, in accordance
 26 with a treatment plan.

27 (2) The treatment plan, upon request by the health benefit plan or health carrier, shall
 28 include all elements necessary for the health benefit plan or health carrier to pay claims. Such
 29 elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and
 30 duration of treatment, and goals.

31 (3) Except for inpatient services, if an individual is receiving treatment for an autism
 32 spectrum disorder, a health carrier shall have the right to review the treatment plan not more than
 33 once every six months unless the health carrier and the individual's treating physician or
 34 psychologist agree that a more frequent review is necessary. Any such agreement regarding the
 35 right to review a treatment plan more frequently shall only apply to a particular individual being
 36 treated for an autism spectrum disorder and shall not apply to all individuals being treated for
 37 autism spectrum disorders by a physician or psychologist. The cost of obtaining any review or
 38 treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

39 5. Coverage provided under this section for applied behavior analysis shall be subject to a
 40 maximum benefit of forty thousand dollars per calendar year for individuals through eighteen years
 41 of age. Such maximum benefit limit may be exceeded, upon prior approval by the health benefit
 42 plan, if the provision of applied behavior analysis services beyond the maximum limit is medically
 43 necessary for such individual. Payments made by a health carrier on behalf of a covered individual
 44 for any care, treatment, intervention, service or item, the provision of which was for the treatment of
 45 a health condition unrelated to the covered individual's autism spectrum disorder, shall not be
 46 applied toward any maximum benefit established under this subsection. Any coverage required
 47 under this section, other than the coverage for applied behavior analysis, shall not be subject to the
 48 age and dollar limitations described in this subsection.

6. The maximum benefit limitation for applied behavior analysis described in subsection 5 of this section shall be adjusted by the health carrier at least triennially for inflation to reflect the aggregate increase in the general price level as measured by the Consumer Price Index for All Urban Consumers for the United States, or its successor index, as defined and officially published by the United States Department of Labor, or its successor agency. Beginning January 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied behavior analysis coverage adjusted for inflation in accordance with this subsection shall be calculated by the director of the department of insurance, financial institutions and professional registration. The director shall furnish the calculated value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021.

7. Subject to the provisions set forth in subdivision (3) of subsection 4 of this section, coverage provided under this section shall not be subject to any limits on the number of visits an individual may make to an autism service provider, except that the maximum total benefit for applied behavior analysis set forth in subsection 5 of this section shall apply to this subsection. 8. This section shall not be construed as limiting benefits which are otherwise available to an individual under a health benefit plan. The health care coverage required by this section shall not be subject to any greater deductible, coinsurance, or co-payment than other physical health care services provided by a health benefit plan. Coverage of services may be subject to other general exclusions and limitations of the contract or benefit plan, not in conflict with the provisions of this section, such as coordination of benefits, exclusions for services provided by family or household members, and utilization review of health care services, including review of medical necessity and care management; however, coverage for treatment under this section shall not be denied on the basis that it is educational or habilitative in nature.

9. To the extent any payments or reimbursements are being made for applied behavior analysis, such payments or reimbursements shall be made to either:

- (1) The autism service provider, as defined in this section; or
- (2) The entity or group for whom such supervising person, who is certified as a board-certified behavior analyst by the Behavior Analyst Certification Board, works or is associated.

Such payments or reimbursements under this subsection to an autism service provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a line therapist under the supervision of such provider or behavior analyst if such services provided by the line therapist are included in the treatment plan and are deemed medically necessary.

10. Notwithstanding any other provision of law to the contrary, health carriers shall not be held liable for the actions of line therapists in the performance of their duties.

11. The provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2011. The terms "employees" and "health care plans" shall have the same meaning ascribed to them in section 103.003.

12. The provisions of this section shall also apply to the following types of plans that are established, extended, modified, or renewed on or after January 1, 2011:

- (1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section 1002(32);
- (2) All self-insured group arrangements, to the extent not preempted by federal law;
- (3) All plans provided through a multiple employer welfare arrangement, or plans provided through another benefit arrangement, to the extent permitted by the Employee Retirement Income

1 Security Act of 1974, or any waiver or exception to that act provided under federal law or
2 regulation; and

3 (4) All self-insured school district health plans.

4 13. The provisions of this section shall not automatically apply to an individually
5 underwritten health benefit plan, but shall be offered as an option to any such plan.

6 14. The provisions of this section shall not apply to a supplemental insurance policy,
7 including a life care contract, accident-only policy, specified disease policy, hospital policy
8 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term
9 major medical policy [~~of six months or less duration~~] having a duration of less than one year, or any
10 other supplemental policy.

11 15. Any health carrier or other entity subject to the provisions of this section shall not be
12 required to provide reimbursement for the applied behavior analysis delivered to a person insured
13 by such health carrier or other entity to the extent such health carrier or other entity is billed for
14 such services by any Part C early intervention program or any school district for applied behavior
15 analysis rendered to the person covered by such health carrier or other entity. This section shall not
16 be construed as affecting any obligation to provide services to an individual under an individualized
17 family service plan, an individualized education plan, or an individualized service plan. This
18 section shall not be construed as affecting any obligation to provide reimbursement pursuant to
19 section 376.1218.

20 16. The provisions of sections 376.383, 376.384, and 376.1350 to 376.1399 shall apply to
21 this section.

22 17. The director of the department of insurance, financial institutions and professional
23 registration shall grant a small employer with a group health plan, as that term is defined in section
24 379.930, a waiver from the provisions of this section if the small employer demonstrates to the
25 director by actual claims experience over any consecutive twelve-month period that compliance
26 with this section has increased the cost of the health insurance policy by an amount of two and a
27 half percent or greater over the period of a calendar year in premium costs to the small employer.

28 18. The provisions of this section shall not apply to the Mo HealthNet program as described
29 in chapter 208.

30 19. (1) By February 1, 2012, and every February first thereafter, the department of
31 insurance, financial institutions and professional registration shall submit a report to the general
32 assembly regarding the implementation of the coverage required under this section. The report shall
33 include, but shall not be limited to, the following:

34 (a) The total number of insureds diagnosed with autism spectrum disorder;

35 (b) The total cost of all claims paid out in the immediately preceding calendar year for
36 coverage required by this section;

37 (c) The cost of such coverage per insured per month; and

38 (d) The average cost per insured for coverage of applied behavior analysis;

39 (2) All health carriers and health benefit plans subject to the provisions of this section shall
40 provide the department with the data requested by the department for inclusion in the annual report.

41 376.1225. 1. All individual and group health insurance policies providing coverage on an
42 expense-incurred basis, individual and group service or indemnity type contracts issued by a
43 nonprofit corporation, individual and group service contracts issued by a health maintenance
44 organization, all self-insured group arrangements to the extent not preempted by federal law and all
45 managed health care delivery entities of any type or description, that are delivered, issued for
46 delivery, continued or renewed on or after August 28, 1998, shall provide coverage for
47 administration of general anesthesia and hospital charges for dental care provided to the following
48 covered persons:

- 1 (1) A child under the age of five;
- 2 (2) A person who is severely disabled; or
- 3 (3) A person who has a medical or behavioral condition which requires hospitalization or
- 4 general anesthesia when dental care is provided.

5 2. Each plan as described in this section must provide coverage for administration of
6 general anesthesia and hospital or office charges for treatment rendered by a dentist, regardless of
7 whether the services are provided in a participating hospital or surgical center or office.

8 3. Nothing in this section shall prevent a health carrier from requiring prior authorization
9 for hospitalization for dental care procedures in the same manner that prior authorization is required
10 for hospitalization for other covered diseases or conditions.

11 4. Nothing in this section shall apply to accident-only, dental-only plans or other specified
12 disease, hospital indemnity, Medicare supplement or long-term care policies, or short-term major
13 medical policies [~~of six months or less in duration~~] having a duration of less than one year.

14 376.1230. 1. Every policy issued by a health carrier, as defined in section 376.1350, shall
15 provide coverage for chiropractic care delivered by a licensed chiropractor acting within the scope
16 of his or her practice as defined in chapter 331. The coverage shall include initial diagnosis and
17 clinically appropriate and medically necessary services and supplies required to treat the diagnosed
18 disorder, subject to the terms and conditions of the policy. The coverage may be limited to
19 chiropractors within the health carrier's network, and nothing in this section shall be construed to
20 require a health carrier to contract with a chiropractor not in the carrier's network nor shall a carrier
21 be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval
22 has been obtained from the carrier by the enrollee. An enrollee may access chiropractic care within
23 the network for a total of twenty-six chiropractic physician office visits per policy period, but may
24 be required to provide the health carrier with notice prior to any additional visit as a condition of
25 coverage. A health carrier may require prior authorization or notification before any follow-up
26 diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of
27 twenty-six in any policy period. The certificate of coverage for any health benefit plan issued by a
28 health carrier shall clearly state the availability of chiropractic coverage under the policy and any
29 limitations, conditions, and exclusions.

30 2. A health benefit plan shall provide coverage for treatment of a chiropractic care condition
31 and shall not establish any rate, term, or condition that places a greater financial burden on an
32 insured for access to treatment for a chiropractic care condition than for access to treatment for
33 another physical health condition.

34 3. The provisions of this section shall not apply to any health plan or contract that is
35 individually underwritten.

36 4. The provisions of this section shall not apply to benefits provided under the Medicaid
37 program.

38 5. The provisions of this section shall not apply to a supplemental insurance policy,
39 including a life care contract, accident-only policy, specified disease policy, hospital policy
40 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term
41 major medical policy [~~of six months' or less duration~~] having a duration of less than one year, or any
42 other similar supplemental policy.

43 376.1232. 1. Each health carrier or health benefit plan that offers or issues health benefit
44 plans which are delivered, issued for delivery, continued, or renewed in this state on or after January
45 1, 2010, shall offer coverage for prosthetic devices and services, including original and replacement
46 devices, as prescribed by a physician acting within the scope of his or her practice. 2. For the
47 purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as
48 defined in section 376.1350.

3. The amount of the benefit for prosthetic devices and services under this section shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under the health benefit plan. If the health benefit plan does not include any annual or lifetime maximums applicable to basic health care services, the amount of the benefit for prosthetic devices and services shall not be subject to an annual or lifetime maximum benefit level. Any co-payment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for prosthetic devices and services shall be no more than the most common amounts applied to the basic health care services required to be provided under the health benefit plan.

4. The provisions of 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, short-term major medical policies ~~[of six months or less duration]~~ having a duration of less than one year, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1235. 1. No health carrier or health benefit plan, as defined in section 376.1350, shall impose a co-payment or coinsurance percentage charged to the insured for services rendered for each date of service by a physical therapist licensed under chapter 334 or an occupational therapist licensed under chapter 324, for services that require a prescription, that is greater than the co-payment or coinsurance percentage charged to the insured for the services of a primary care physician licensed under chapter 334 for an office visit.

2. A health carrier or health benefit plan shall clearly state the availability of physical therapy and occupational therapy coverage under its plan and all related limitations, conditions, and exclusions.

3. Beginning September 1, 2016, 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 the provisions of this section regarding occupational therapy coverage were enacted. By December 31, 2016, 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 both the house of representatives and senate standing committees having jurisdiction over health insurance matters. If the fiscal note cost estimation is less than the cost of an actuarial analysis, the actuarial analysis requirement shall be waived.

4. This section shall not apply to short-term major medical policies having a duration of less than one year.

376.1237. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, and that provides coverage for prescription eye drops shall provide coverage for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals as long as the prescribing health care provider authorizes such early refill, and the health carrier or the health benefit plan is notified.

2. For the purposes of this section, health carrier and health benefit plan shall have the same meaning as defined in section 376.1350.

3. The coverage required by this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the health benefit plan.

4. The provisions of 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, short-term

major medical policies [~~of six months' or less duration~~] having a duration of less than one year, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

5. The provisions of this section shall terminate on January 1, 2020.

376.1250. 1. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after August 28, 1999, and providing coverage to any resident of this state shall provide benefits or coverage for:

(1) A pelvic examination and pap smear for any nonsymptomatic woman covered under such policy or contract, in accordance with the current American Cancer Society guidelines;

(2) A prostate examination and laboratory tests for cancer for any nonsymptomatic man covered under such policy or contract, in accordance with the current American Cancer Society guidelines; and

(3) A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person covered under such policy or contract, in accordance with the current American Cancer Society guidelines.

2. Coverage and benefits related to the examinations and tests as required by this section shall be at least as favorable and subject to the same dollar limits, deductible, and co-payments as other covered benefits or services.

3. Nothing in this act shall apply to accident-only, hospital indemnity, Medicare supplement, long-term care, or other limited benefit health insurance policies.

4. The provisions of this section shall not apply to short-term major medical policies [~~of six months or less duration~~] having a duration of less than one year.

5. The attending physician shall advise the patient of the advantages, disadvantages, and risks, including cancer, associated with breast implantation prior to such operation.

6. Nothing in this section shall alter, impair or otherwise affect claims, rights or remedies available pursuant to law.

376.1253. 1. Each physician attending any patient with a newly diagnosed cancer shall inform the patient that the patient has the right to a referral for a second opinion by an appropriate board-certified specialist prior to any treatment. If no specialist in that specific cancer diagnosis area is in the provider network, a referral shall be made to a nonnetwork specialist in accordance with this section.

2. Each health carrier or health benefit plan, as defined in section 376.1350, that offers or issues health benefit plans which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2003, shall provide coverage for a second opinion rendered by a specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Such coverage shall be subject to the same deductible and coinsurance conditions applied to other specialist referrals and all other terms and conditions applicable to other benefits, including the prior authorization and/or referral authorization requirements as specified in the applicable health insurance policy.

3. The provisions of 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, short-term major medical policies [~~of six months' or less duration~~] having a duration of less than one year, or any other supplemental policy as determined by the director of the department of insurance,

1 financial institutions and professional registration.

2 376.1257. 1. As used in this section the following terms shall mean:

3 (1) "Anticancer medications", medications used to kill or slow the growth of cancerous
4 cells;

5 (2) "Covered person", a policyholder, subscriber, enrollee, or other individual enrolled in or
6 insured by a health benefit plan for health insurance coverage;

7 (3) "Health benefit plan", shall have the same meaning as defined in section 376.1350.

8 2. Any health benefit plan that provides coverage and benefits for cancer treatment shall
9 provide coverage of prescribed orally administered anticancer medications on a basis no less
10 favorable than intravenously administered or injected anticancer medications.

11 3. Coverage of orally administered anticancer medication shall not be subject to any prior
12 authorization, dollar limit, co-payment, deductible, or other out-of-pocket expense that does not
13 apply to intravenously administered or injected anticancer medication, regardless of formulation or
14 benefit category determination by the company administering the health benefit plan.

15 4. The health benefit plan shall not reclassify or increase any type of cost-sharing to the
16 covered person for anticancer medications in order to achieve compliance with this section. Any
17 change in health insurance coverage, which otherwise increases an out-of-pocket expense to
18 anticancer medications, shall be applied to the majority of comparable medical or pharmaceutical
19 benefits covered by the health benefit plan.

20 5. Notwithstanding the provisions of subsections 2, 3, and 4 of this section, a health benefit
21 plan that limits the total amounts paid by a covered person through all cost-sharing requirements to
22 no more than seventy-five dollars per thirty-day supply for any orally administered anticancer
23 medication shall be considered in compliance with this section. On January 1, 2016, and on January
24 first of each year thereafter, a health benefit plan may adjust such seventy-five dollar limit. The
25 adjustment shall not exceed the Consumer Price Index for All Urban Consumers Midwest Region
26 for that year. For purposes of this subsection "cost-sharing requirements" shall include co-
27 payments, coinsurance, deductibles, and any other amounts paid by the covered person for that
28 prescription.

29 6. For a health benefit plan that meets the definition of "high deductible health plan" as
30 defined by 26 U.S.C. 223(c)(2), the provisions of subsection 5 of this section shall only apply after a
31 covered person's deductible has been satisfied for the year.

32 7. The provisions of this section shall not apply to short-term major medical policies having
33 a duration of less than one year.

34 8. The provisions of this section shall become effective January 1, 2015.

35 376.1275. 1. Each health carrier or health benefit plan that offers or issues health benefit
36 plans which are delivered, issued for delivery, continued, or renewed in this state on or after January
37 1, 2003, shall include coverage for their members for the cost for human leukocyte antigen testing,
38 also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization
39 in bone marrow transplantation. The testing must be performed in a facility which is accredited by
40 the American Association of Blood Banks or its successors, and is licensed under the Clinical
41 Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the
42 American Association of Blood Banks or its successors, the College of American Pathologists, the
43 American Society for Histocompatibility and Immunogenetics (ASHI) or any other national
44 accrediting body with requirements that are substantially equivalent to or more stringent than those
45 of the College of American Pathologists. At the time of testing, the person being tested must
46 complete and sign an informed consent form which also authorizes the results of the test to be used
47 for participation in the National Marrow Donor Program. The health benefit plan may limit each
48 enrollee to one such testing per lifetime to be reimbursed at a cost of no greater than seventy-five

dollars by the health carrier or health benefit plan.

2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as defined in section 376.1350.

3. The health care service required by this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the health benefit plan.

4. The provisions of 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, short-term major medical policies [~~of six months' or less duration~~] having a duration of less than one year, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1290. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements, to the extent not preempted by federal law, and all managed health care delivery entities of any type or description that are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002, shall offer coverage for testing pregnant women for lead poisoning and for all testing for lead poisoning authorized by sections 701.340 to 701.349 or by rule of the department of health and senior services promulgated pursuant to sections 701.340 to 701.349.

2. Health care services required by this section shall not be subject to any greater deductible or co-payment than any other health care service provided by the policy, contract or plan.

3. No entity enumerated in subsection 1 of this section shall reduce or eliminate coverage as a result of the requirements of this section.

4. Nothing in this section shall apply to short-term major medical policies having a duration of one year or less, or to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

376.1400. 1. Every health insurance carrier offering policies of insurance in this state shall use standardized information for the explanation of benefits given to the health care provider whenever a claim is paid or denied. As used in this section, the term "health insurance carrier" shall have the meaning given to "health carrier" in section 376.1350. Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, short-term major medical policies [~~of six months' or less duration~~] having a duration of less than one year, other limited benefit health insurance policies.

2. The standardized information shall contain the following:

- (1) The name of the insured;
- (2) The insured's identification number;
- (3) The date of service;
- (4) Amount of charge;
- (5) Explanation for any denial;
- (6) The amount paid;
- (7) The patient's full name;
- (8) The name and address of the insurer; and
- (9) The phone number to contact for questions on explanation of benefits.

3. All health insurance carriers shall use the standard explanation of benefits information after January 1, 2002.

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) 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 in this subsection:

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

(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 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.

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;

(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) "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) "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) "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.

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, 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~~] having a duration of less than one year, 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.

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, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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.

376.1900. 1. As used in this section, the following terms shall mean:

(1) "Electronic visit", or "e-visit", an online electronic medical evaluation and management service completed using a secured web-based or similar electronic-based communications network for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of a patient with the health care provider, be completed using a federal Health Insurance Portability and Accountability Act (HIPAA)-compliant online connection, and include a permanent record of the electronic visit;

(2) "Health benefit plan" shall have the same meaning ascribed to it in section 376.1350;

(3) "Health care provider" shall have the same meaning ascribed to it in section 376.1350;

(4) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a physical or mental health condition, illness, injury or disease;

(5) "Health carrier" shall have the same meaning ascribed to it in section 376.1350;

(6) "Telehealth" shall have the same meaning ascribed to it in section 208.670.

2. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, shall not deny coverage for a health care service on the basis that the health care service is provided through telehealth if the same service would be covered if provided through face-to-face diagnosis, consultation, or treatment.

1 3. A health carrier may not exclude an otherwise covered health care service from coverage
2 solely because the service is provided through telehealth rather than face-to-face consultation or
3 contact between a health care provider and a patient.

4 4. A health carrier shall not be required to reimburse a telehealth provider or a consulting
5 provider for site origination fees or costs for the provision of telehealth services; however, subject to
6 correct coding, a health carrier shall reimburse a health care provider for the diagnosis, consultation,
7 or treatment of an insured or enrollee when the health care service is delivered through telehealth on
8 the same basis that the health carrier covers the service when it is delivered in person.

9 5. A health care service provided through telehealth shall not be subject to any greater
10 deductible, co-payment, or coinsurance amount than would be applicable if the same health care
11 service was provided through face-to-face diagnosis, consultation, or treatment.

12 6. A health carrier shall not impose upon any person receiving benefits under this section
13 any co-payment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime, or
14 other durational benefit limitation or maximum for benefits or services that is not equally imposed
15 upon all terms and services covered under the policy, contract, or health benefit plan. 7.
16 Nothing in this section shall preclude a health carrier from undertaking utilization review to
17 determine the appropriateness of telehealth as a means of delivering a health care service, provided
18 that the determinations shall be made in the same manner as those regarding the same service when
19 it is delivered in person.

20 8. A health carrier or health benefit plan may limit coverage for health care services that are
21 provided through telehealth to health care providers that are in a network approved by the plan or
22 the health carrier.

23 9. Nothing in this section shall be construed to require a health care provider to be
24 physically present with a patient where the patient is located unless the health care provider who is
25 providing health care services by means of telehealth determines that the presence of a health care
26 provider is necessary.

27 10. The provisions of this section shall not apply to a supplemental insurance policy,
28 including a life care contract, accident-only policy, specified disease policy, hospital policy
29 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term
30 major medical policies [~~of six months' or less duration~~] having a duration of less than one year, or
31 any other supplemental policy as determined by the director of the department of insurance,
32 financial institutions and professional registration."; and
33

34 Further amend said bill and page, Section B, Lines 2 and 5, by deleting each instance of the phrase
35 "section 195.070" and inserting in lieu thereof the phrase "sections 195.070 and 195.265"; and
36

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