House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Committee Substitute for House Bill No. 1685, Page 1, Section A, Line 8, by inserting after all of said line the following:

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

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

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

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

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

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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 1, Section 376.008, Line 1, by deleting all of said line and inserting in lieu thereof the following:

"376.008. 1. All short-term major medical policies delivered or issued for delivery in this state shall include on any"; and

Further amend said section, Page 2, Line 10, by inserting after all of said line the following:

"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) Coverage limits, if any, expressed in dollars for:

(a) Each occurrence;

(b) Each covered benefit, including but not limited to any benefit that is or was a covered benefit for any duration or dollar amount during the contract period and anything included under subdivision (2) of this subsection; and

(c) Each contract period;

(2) Copayments and deductibles for each covered benefit, including but not limited to:

(a) Inpatient hospital care;

(b) Outpatient hospital care;

(c) Nonhospital inpatient care;

(d) Nonhospital outpatient care;

(e) Prescription drugs; and

(f) Emergency services; and

(3) Any copayment or deductible for an illness or affliction which differs from the copayment or deductible required to be described under subdivision (2) of this subsection."; and

Further amend said bill, Page 5, Section 376.446, Line 14, by inserting after all of said line the following:

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

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

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

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

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

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

(5) The health insurance issuer is ceasing to offer coverage in the large group market in accordance with subsection 3 of this section;

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

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

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

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

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

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

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

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

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

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

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

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

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

2. A health insurance issuer may nonrenew or discontinue health insurance coverage of an

individual in the individual market based only on one or more of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. In applying this section in the case of health insurance coverage that is made available by

a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an individual is deemed to include a reference to such an association of which the individual is a member.

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

Further amend said bill, Page 7, Section 376.781, Line 33, by inserting after all of said line the following:

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

2. 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, 1991, and providing coverage to any resident of this state shall provide benefits or coverage for low-dose mammography screening for any nonsymptomatic woman covered under such policy or contract which meets the minimum requirements of this section. Such benefits or coverage shall include at least the following:

(1) A baseline mammogram for women age thirty-five to thirty-nine, inclusive;

(2) A mammogram for women age forty to forty-nine, inclusive, every two years or more frequently based on the recommendation of the patient's physician;

(3) A mammogram every year for women age fifty and over;

(4) A mammogram for any woman, upon the recommendation of a physician, where such woman, her mother or her sister has a prior history of breast cancer.

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

4. The provisions of this section shall not apply to short-term major medical policies having a duration of less than one year."; and

Further amend said bill, Page 16, Section 376.1200, Line 32, by inserting after all of said line the following:

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

376.1210. 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 are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1997, and providing for maternity benefits, shall provide coverage for a minimum of forty-eight hours of inpatient care following a vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean section for a mother and her newly born child in a hospital as defined in section 197.020 or any other health care facility licensed to provide obstetrical care under the provisions of chapter 197.

2. Notwithstanding the provisions of subsection 1 of this section, any 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 are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1997, and providing for maternity benefits, may authorize a shorter length of hospital stay for services related to maternity and newborn care if:

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

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

3. Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical

criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending physician as medically appropriate.

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

5. 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 shall provide notice to policyholders, insured persons and participants regarding the coverage required by this section. Such notice shall be in writing and prominently positioned in the policy, certificate of coverage or summary plan description.

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

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

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

9. The department of insurance, financial institutions and professional registration shall adopt rules and regulations to implement and enforce 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 the provisions of section 536.024."; and

Further amend said bill, Page 29, Section 376.1253, Line 19, by inserting after all of said line the following:

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

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

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

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

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

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

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

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

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

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

8. The provisions of this section shall become effective January 1, 2015."; and

Further amend said bill, Page 30, Section 376.1275 Line 26, by inserting after all of said line the following:

"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."; and

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