House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND Senate Substitute for Senate Bill No. 982, Page 1, Section A, Line 3, by inserting after all of said line the following;

"354.150. 1. Every health services corporation subject to the provisions of sections 354.010 to 354.380 shall pay **[**~~the following fees~~**]** to the director **[**~~for the administration and enforcement of the provisions of this chapter:~~

~~(1) For filing the declaration required on organization of each domestic company, two hundred fifty dollars;~~

~~(2) For filing statement and certified copy of charter required of foreign companies, two hundred fifty dollars;~~

~~(3) For filing application to renew certificate of authority, along with all required annual reports, including the annual statement, actuarial statement, risk-based capital report, report of valuation of policies or other obligations of assurance, and audited financial report of any company doing business in this state, one thousand five hundred dollars;~~

~~(4) For filing any paper, document, or report not filed under subdivision (1), (2), or (3) of this section but required to be filed in the office of the director, fifty dollars each;~~

~~(5) For affixing the seal of office of the director, ten dollars;~~

~~(6) For accepting each service of process upon the company, ten dollars~~**]** the fees specified in section 374.230.

2. Fees mandated in subdivision (1) of **[**~~subsection 1 of this section~~**]** section 374.230 shall be waived if a majority shareholder, officer, or director of the organizing corporation is a member of the Missouri National Guard or any other active duty military, resides in the state of Missouri, and provides proof of such service to the secretary of state.

354.495. Every health maintenance organization subject to sections 354.400 to 354.636 shall pay to the director the **[**~~following fees:~~

~~(1) For filing the declaration required on organization of each domestic company, two hundred fifty dollars;~~

~~(2) For filing statement and certified copy of charter required of foreign companies, two hundred fifty dollars;~~

~~(3) For filing application to renew certificate of authority, along with all required annual reports, including the annual statement, actuarial statement, risk based capital report, report of valuation of policies or other obligations of assurance, and audited financial report of any company doing business in this state, one thousand five hundred dollars;~~

~~(4) For filing any paper, document, or report not filed under subdivision (1), (2), or (3) of this section but required to be filed in the office of the director, fifty dollars each;~~

~~(5) For affixing the seal of office of the director, ten dollars;~~

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~~(6) For accepting each service of process upon the company, ten dollars~~**]** fees specified in section 374.230.

354.603. 1. A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable delay. In the case of emergency services, enrollees shall have access twenty-four hours per day, seven days per week. The health carrier's medical director shall be responsible for the sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by the director in accordance with the requirements of this section and by reference to any reasonable criteria, including but not limited to provider-enrollee ratios by specialty, primary care provider-enrollee ratios, geographic accessibility, reasonable distance accessibility criteria for pharmacy and other services, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(1) In any case where the health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers, including local pharmacists, to the business or personal residence of enrollees. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under, especially rural areas, consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its providers to furnish all contracted benefits to enrollees. The provisions of this subdivision shall not be construed to require any health care provider to submit copies of such health care provider's income tax returns to a health carrier. A health carrier may require a health care provider to obtain audited financial statements if such health care provider received ten percent or more of the total medical expenditures made by the health carrier.

(4) A health carrier shall make its entire network available to all enrollees unless a contract holder has agreed in writing to a different or reduced network.

2. A health carrier shall file with the director, in a manner and form defined by rule of the department of insurance, financial institutions and professional registration, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing. The access plan shall describe or contain at a minimum the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

(4) The health carrier's methods for assessing the health care needs of enrollees and their

satisfaction with services;

(5) The health carrier's method of informing enrollees of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling enrollees to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, in the event of a reduction in service area or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the health carrier's insolvency or other modification or cessation of operations, and transferred to other health care professionals in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 354.600 to 354.636.

3. In reviewing an access plan filed pursuant to subsection 2 of this section, the director shall deem a managed care plan's network to be adequate if it meets one or more of the following criteria:

(1) The managed care plan is a Medicare + Choice coordinated care plan offered by the health carrier pursuant to a contract with the federal Centers for Medicare and Medicaid Services;

(2) The managed care plan is being offered by a health carrier that has been accredited by the National Committee for Quality Assurance at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed;

(3) The managed care plan's network has been accredited by the Joint Commission on the Accreditation of Health Organizations for Network Adequacy, and such accreditation is in effect at the time the access plan is filed. If the accreditation applies to only a portion of the managed care plan's network, only the accredited portion will be deemed adequate; [or]

(4) The managed care plan is being offered by a health carrier that has been accredited by the Utilization Review Accreditation Commission at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed; or

(5) The managed care plan is being offered by a health carrier that has been accredited by the Accreditation Association for Ambulatory Health Care, and such accreditation is in effect at the time the access plan is filed.

374.150. 1. All fees due the state under the provisions of the insurance laws of this state shall be paid to the director **[**~~of revenue~~**]** and deposited in the state treasury to the credit of the insurance dedicated fund unless otherwise provided for in subsection 2 of this section.

2. There is hereby established in the state treasury a special fund to be known as the "Insurance Dedicated Fund". The fund shall be subject to appropriation of the general assembly and shall be devoted solely to the payment of expenditures incurred by the department attributable to duties performed by the department for the regulation of the business of insurance, regulation of health maintenance organizations and the operation of the division of consumer affairs as required by law which are not paid for by another source of funds. Other provisions of law to the contrary notwithstanding, beginning on January 1, 1991, all fees charged under any provision of chapter 325, 354, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384 or 385 due the state shall be paid into this fund. The state treasurer shall invest moneys in this fund in the same manner as other state funds and any interest or earnings on such moneys shall be credited to the insurance dedicated fund. The provisions of section 33.080 notwithstanding, moneys in the fund shall not lapse, be transferred

to or placed to the credit of the general revenue fund unless and then only to the extent to which the unencumbered balance at the close of the biennium year exceeds two times the total amount appropriated, paid, or transferred to the fund during such fiscal year.

[~~3. Notwithstanding provisions of this section to the contrary, five hundred thousand dollars of the insurance dedicated fund shall annually be transferred and placed to the credit of the state general revenue fund on July first beginning with fiscal year 2014.~~**]**

374.230. Every **[**~~insurance company doing business in this state~~**]** individual or entity making a filing with the department described below shall pay to the director **[**~~of revenue~~**]** the following fees and charges, to be paid into the insurance dedicated fund established under section 374.150:

(1) For filing the declaration required on organization of each domestic company, **[**~~two hundred fifty~~**]** one thousand dollars;

(2) For filing statement and certified copy of charter required of foreign companies, **[**~~two hundred fifty~~**]** one thousand dollars;

(3) For filing application to renew certificate of authority, along with all required annual reports, including the annual statement, actuarial statement, risk-based capital report, report of valuation of policies or other obligations of assurance, and audited financial report annual statement of any company doing business in this state, **[**~~one thousand five hundred~~**]** two thousand dollars;

(4) **[**~~For filing supplementary annual statement of any company doing business in this state, fifty dollars~~**]** For filing the ORSA summary report required by sections 382.500 to 382.550, or a preacquisition notification required by sections 382.040 through 382.060, or section 382.095, five hundred dollars;

(5) Unless otherwise specified in subdivision (4) or another section of law, for any filings required under chapter 382, two hundred fifty dollars;

(6) For filing any paper, document, or report for which a filing fee is not otherwise provided for in another section of law that is not filed under subdivision (1), (2), **[**~~or~~**]** (3), (4), or (5), but required to be filed in the office of the director, **[**~~fifty~~**]** one hundred fifty dollars each**[**~~;~~**]** .

[~~(6) For a copy of a company's certificate of authority or producer or agent license, ten dollars;~~

~~(7) For affixing the seal of office of the director, ten dollars;~~

~~(8) For accepting each service of process upon the company, ten dollars.~~**]**"; and

Further amend said bill, Page 1, Section 376.427, Lines 2 through 4, by deleting all of said lines and inserting in lieu thereof the following:

"(1) "Health benefit plan", as such term is defined in section 376.1350;

(2) "Health care services", medical, surgical, dental, podiatric, pharmaceutical, chiropractic, licensed ambulance service, and optometric services;

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

[(2)] (4) "Insured", any person entitled to benefits under a contract of accident"; and

Further amend said section by renumbering accordingly; and

Further amend said bill, Pages 2-5, Section 376.690, Lines 1-92, by deleting all of said lines and inserting in lieut thereof the following:

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

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged;

2. Health care professionals may send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within one hundred and eighty days of the delivery of the unanticipated out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

(1) Within forty-five processing days, as defined in 376.383, of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's services. If the health care professional participates in one or more of the carrier's commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.

(2) If the health care professional declines the health carrier's initial offer of reimbursement, the health carrier and health care professional shall have sixty days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care.

(3) If the health carrier and health care professional do not agree to a reimbursement amount by the end of the sixty day negotiation period, the dispute shall be resolved through an arbitration process as specified in subsection 4 of this section.

(4) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within 120 days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A claim for unanticipated out of network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (2) through (4) of this subsection.

(5) No health care professional who sends a claim to a health carrier under subsection 2 of this section shall send a bill to the patient for any difference between the reimbursement rate as determined under this subsection and the health care professional's billed charge.

3. When unanticipated out-of-network care is provided, the health care professional who sends a claim to a health carrier under subsection 2 of this section may bill a patient for no more than the cost-sharing requirements described under this section.

(1) Cost-sharing requirements shall be based on the reimbursement amount as determined under subsection 2 of this section.

(2) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within forty-five processing days of receiving a claim from the health care professional for services provided.

(3) The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care.

4. The director shall ensure access to an external arbitration process when a health care professional and health carrier cannot agree to a reimbursement under subdivision (2) of subsection 2 of this section. In order to ensure access, when notified of a parties' intent to arbitrate, the director

shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between and will be directly billed to the health care professional and health carrier. These costs will include, but are not limited to, reasonable time necessary for the arbitrator to review materials in preparation for the arbitration, travel expenses and reasonable time following the arbitration for drafting of the final decision.

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the Department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

7. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. This section shall take effect on January 1, 2019.

10. The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to, procedural requirements for arbitration. 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, 2018, shall be invalid and void.

376.1065. 1. As used in this section, the following terms shall mean:

(1) "Contracting entity", any health carrier, as such term is defined in section 376.1350, subject to the jurisdiction of the department engaged in the act of contracting with providers for the delivery of dental services, or the selling or assigning of dental network plans to other entities under the jurisdiction of the department;

(2) "Department", the department of insurance, financial institutions and professional registration;

(3) "Official notification," written communication by a provider or participating provider to a contracting entity describing such provider's or participating provider's change in contact information or participation status with the contracting entity;

(4) "Participating provider", a provider who has an agreement with a contracting entity to provide dental services with an expectation of receiving payment, other than coinsurance, co-payments, or deductibles, directly or indirectly from such contracting entity;

(5) "Provider", any person licensed under chapter 332.

2. A contracting entity shall, upon official notification, make changes contained in the official notification to their electronic provider material and their next edition of paper material made available to plan members or other potential plan members.

3. The department, when determining the result of a market conduct examination under sections 374.202 to 374.207, shall consider violations of this section by a contracting entity."; and

Further amend said bill, Page 5, Section 376.1063, Lines 1 through 16, by removing all of said section from the bill; and

Further amend said bill, Page 10, Section 376.1367, Line 15, by inserting after the word, "forty-five" the word, "processing"; and

Further amend said page and section, Line 34, by inserting after all of said line the following:

"379.1545. Notwithstanding any other provision of law:

(1) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty days' notice;

(2) If the insurer changes the terms and conditions of a policy of portable electronics insurance, the insurer shall provide the vendor and any policyholders with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of material changes;

(3) Notwithstanding subdivision (1) of this section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder;

(4) Notwithstanding subdivision (1) of this section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(a) For nonpayment of premium;

(b) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(c) If an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the customer within thirty calendar days after exhaustion of the limit. However, if the notice is not timely sent, enrollment and coverage shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer;

(5) Where a portable electronics insurance policy is terminated by a policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the customer of

the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the customer at least thirty days prior to the termination;

(6) Whenever notice is required under this section, it shall be in writing and may be mailed or delivered to the vendor at the vendor's mailing address and to its affected enrolled customers' last known mailing addresses on file with the insurer. If notice is mailed, the insurer or vendor, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the U.S. Postal Service or other commercial mail delivery service. Alternatively, an insurer or vendor policyholder may comply with any notice required by this section by providing electronic notice to a vendor or its affected enrolled customers, as the case may be, by electronic means. For purposes of this subdivision, agreement to receive notices and correspondence by electronic means shall be determined in accordance with section 432.220. Additionally, if an insurer or vendor policyholder provides electronic notice to an affected enrolled customer and such delivery by electronic means is not available or is undeliverable, the insurer or vendor policyholder shall provide written notice to the enrolled customer by mail in accordance with this section. If notice is accomplished through electronic means, the insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice was sent.

[~~374.115. Insurance examiners appointed or employed by the director of the department of insurance, financial institutions and professional registration shall be compensated according to the applicable levels established and published by the National Association of Insurance Commissioners.~~**]**

Section B. The repeal of section 374.115 and the repeal and reenactment of sections 354.150, 354.495, 374.150, and 374.230 of section A of this act shall become effective on January 1, 2019."; and

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