

House _____ Amendment NO. _____

Offered By

1 AMEND House Committee Substitute for Senate Bill No. 275, Page 51, Section 338.800, Line 20,
2 by inserting after all of said section and line the following:

3
4 "374.500. As used in sections 374.500 to 374.515, the following terms mean:

5 (1) "Certificate", a certificate of registration granted by the department of insurance,
6 financial institutions and professional registration to a utilization review agent;

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

9 (3) "Enrollee", an individual who has contracted for or who participates in coverage under a
10 health insurance policy, an employee welfare benefit plan, a health services corporation plan or any
11 other benefit program providing payment, reimbursement or indemnification for health care costs
12 for himself or eligible dependents or both himself and eligible dependents. The term "enrollee"
13 shall not include an individual who has health care coverage pursuant to a liability insurance policy,
14 workers' compensation insurance policy, or medical payments insurance issued as a supplement to a
15 liability policy;

16 (4) "Provider of record", the physician or other licensed practitioner identified to the
17 utilization review agent as having primary responsibility for the care, treatment and services
18 rendered to an enrollee;

19 (5) "Utilization review", a set of formal techniques designed to monitor the use of, or
20 evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services,
21 procedures, or settings. Techniques may include ambulatory review, ~~prospective~~ prior
22 authorization review, second opinion, certification, concurrent review, case management, discharge
23 planning or retrospective review. Utilization review shall not include elective requests for
24 clarification of coverage;

25 (6) "Utilization review agent", any person or entity performing utilization review, except:

26 (a) An agency of the federal government;

27 (b) An agent acting on behalf of the federal government, but only to the extent that the agent
28 is providing services to the federal government; or

29 (c) Any individual person employed or used by a utilization review agent for the purpose of
30 performing utilization review services, including, but not limited to, individual nurses and
31 physicians, unless such individuals are providing utilization review services to the applicable benefit
32 plan, pursuant to a direct contractual relationship with the benefit plan;

33 (d) An employee health benefit plan that is self-insured and qualified pursuant to the federal
34 Employee Retirement Income Security Act of 1974, as amended;

35 (e) A property-casualty insurer or an employee or agent working on behalf of a property-
36 casualty insurer;

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(f) A health carrier, as defined in section 376.1350, that is performing a review of its own health plan;

(7) "Utilization review plan", a summary of the utilization review procedures of a utilization review agent."; and

Further amend said bill, Page 54, Section 376.690, Line 95, by inserting after all of said section and line the following:

"376.1040. 1. No multiple employer self-insured health plan shall be offered or advertised to the public [generally]. No plan shall be sold, solicited, or marketed by persons or entities defined in section 375.012 or sections 376.1075 to 376.1095. Multiple employer self-insured health plans with a certificate of authority approved by the director under section 376.1002 shall be exempt from the restrictions set forth in this section.

2. A health carrier acting as an administrator for a multiple employer self insured health plan shall permit any willing licensed broker to quote, sell, solicit, or market such plan to the extent permitted by this section; provided that such broker is appointed and in good standing with the health carrier and completes all required training.

376.1042. The sale, solicitation or marketing of any plan in violation of section 376.1040 by an agent, agency or broker shall constitute a violation of section 375.141.

376.1345. 1. As used in this section, unless the context clearly indicates otherwise, terms shall have the same meaning as ascribed to them in section 376.1350.

2. No health carrier, nor any entity acting on behalf of a health carrier, shall restrict methods of reimbursement to health care providers for health care services to a reimbursement method requiring the provider to pay a fee, discount the amount of their claim for reimbursement, or remit any other form of remuneration in order to redeem the amount of their claim for reimbursement.

3. If a health carrier initiates or changes the method used to reimburse a health care provider to a method of reimbursement that will require the health care provider to pay a fee, discount the amount of its claim for reimbursement, or remit any other form of remuneration to the health carrier or any entity acting on behalf of the health carrier in order to redeem the amount of its claim for reimbursement, the health carrier or an entity acting on its behalf shall:

(1) Notify such health care provider of the fee, discount, or other remuneration required to receive reimbursement through the new or different reimbursement method; and

(2) In such notice, provide clear instructions to the health care provider as to how to select an alternative payment method, and upon request such alternative payment method shall be used to reimburse the provider until the provider requests otherwise.

4. A health carrier shall allow the provider to select to be reimbursed by an electronic funds transfer through the Automated Clearing House Network as required pursuant to 45 C.F.R. Sections 162.925, 162.1601, and 162.1602, and if the provider makes such selection, the health carrier shall use such reimbursement method to reimburse the provider until the provider requests otherwise.

5. Violation of this section shall be deemed an unfair trade practice under sections 375.930 to 375.948.

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or ~~[its designee]~~ a utilization review ~~[organization]~~ entity that an admission, availability of care, continued stay or other health care service furnished or proposed to be furnished to an enrollee has been reviewed and, based upon the information provided, does not meet the utilization review entity or health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or are experimental or investigational, and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or ~~[its designee]~~ a utilization review [organization] entity that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness, and that payment will be made for that health care service provided the patient is an enrollee of the health benefit plan at the time the service is provided;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, decision abstracts, clinical protocols [and], medical protocols, practice guidelines, and any other criteria or rationale used by the health carrier or utilization review entity to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

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

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery;

or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating

1 in a health benefit plan;

2 (15) "FDA", the federal Food and Drug Administration;

3 (16) "Facility", an institution providing health care services or a health care setting,
4 including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or
5 treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and
6 imaging centers, and rehabilitation and other therapeutic health settings;

7 (17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding
8 the:

9 (a) Availability, delivery or quality of health care services, including a complaint regarding
10 an adverse determination made pursuant to utilization review;

11 (b) Claims payment, handling or reimbursement for health care services; or

12 (c) Matters pertaining to the contractual relationship between an enrollee and a health
13 carrier;

14 (18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered
15 or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of
16 health care services; except that, health benefit plan shall not include any coverage pursuant to
17 liability insurance policy, workers' compensation insurance policy, or medical payments insurance
18 issued as a supplement to a liability policy;

19 (19) "Health care professional", a physician or other health care practitioner licensed,
20 accredited or certified by the state of Missouri to perform specified health services consistent with
21 state law;

22 (20) "Health care provider" or "provider", a health care professional or a facility;

23 (21) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief
24 of a health condition, illness, injury or disease, including but not limited to the provision of drugs or
25 durable medical equipment;

26 (22) "Health carrier", an entity subject to the insurance laws and regulations of this state that
27 contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs
28 of health care services, including a sickness and accident insurance company, a health maintenance
29 organization, a nonprofit hospital and health service corporation, or any other entity providing a plan
30 of health insurance, health benefits or health services; except that such plan shall not include any
31 coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or
32 medical payments insurance issued as a supplement to a liability policy;

33 (23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

34 (24) "Managed care plan", a health benefit plan that either requires an enrollee to use, or
35 creates incentives, including financial incentives, for an enrollee to use, health care providers
36 managed, owned, under contract with or employed by the health carrier;

37 (25) "Participating provider", a provider who, under a contract with the health carrier or with
38 its contractor or subcontractor, has agreed to provide health care services to enrollees with an
39 expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or
40 indirectly from the health carrier;

41 (26) "Peer-reviewed medical literature", a published scientific study in a journal or other
42 publication in which original manuscripts have been published only after having been critically
43 reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that
44 has been determined by the International Committee of Medical Journal Editors to have met the
45 uniform requirements for manuscripts submitted to biomedical journals or is published in a journal
46 specified by the United States Department of Health and Human Services pursuant to Section
47 1861(t)(2)(B) of the Social Security Act (42 U.S.C. 1395x), as amended, as acceptable peer-
48 reviewed medical literature. Peer-reviewed medical literature shall not include publications or
49 supplements to publications that are sponsored to a significant extent by a pharmaceutical

1 manufacturing company or health carrier;

2 (27) "Person", an individual, a corporation, a partnership, an association, a joint venture, a
3 joint stock company, a trust, an unincorporated organization, any similar entity or any combination
4 of the foregoing;

5 (28) "Prior authorization", a certification made pursuant to a prior authorization review, or
6 notice as required by a health carrier or utilization review entity prior to the provision of health care
7 services;

8 (29) "[Prospective review] Prior authorization review", utilization review conducted prior to
9 an admission or a course of treatment, including but not limited to pre-admission review, pre-
10 treatment review, utilization review, and case management;

11 [(29)] (30) "Retrospective review", utilization review of medical necessity that is conducted
12 after services have been provided to a patient, but does not include the review of a claim that is
13 limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or
14 adjudication for payment;

15 [(30)] (31) "Second opinion", an opportunity or requirement to obtain a clinical evaluation
16 by a provider other than the one originally making a recommendation for a proposed health service
17 to assess the clinical necessity and appropriateness of the initial proposed health service;

18 [(31)] (32) "Stabilize", with respect to an emergency medical condition, that no material
19 deterioration of the condition is likely to result or occur before an individual may be transferred;

20 [(32)] (33) "Standard reference compendia":

21 (a) The American Hospital Formulary Service-Drug Information; or

22 (b) The United States Pharmacopoeia-Drug Information;

23 [(33)] (34) "Utilization review", a set of formal techniques designed to monitor the use of,
24 or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services,
25 procedures, or settings. Techniques may include ambulatory review, [prospective] prior
26 authorization review, second opinion, certification, concurrent review, case management, discharge
27 planning or retrospective review. Utilization review shall not include elective requests for
28 clarification of coverage;

29 [(34)] (35) "Utilization review [organization] entity", a utilization review agent as defined in
30 section 374.500, or an individual or entity that performs prior authorization reviews for a health
31 carrier or health care provider. A health carrier or health care provider is a utilization review entity
32 if it performs prior authorization review.

33 376.1356. Whenever a health carrier contracts to have a utilization review ~~[organization or~~
34 ~~other]~~ entity perform the utilization review functions required by sections 376.1350 to 376.1390 or
35 applicable rules and regulations, the health carrier shall be responsible for monitoring the activities
36 of the utilization review ~~[organization or]~~ entity with which the health carrier contracts and for
37 ensuring that the requirements of sections 376.1350 to 376.1390 and applicable rules and
38 regulations are met.

39 376.1363. 1. A health carrier shall maintain written procedures for making utilization
40 review decisions and for notifying enrollees and providers acting on behalf of enrollees of its
41 decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

42 2. For ~~[initial]~~ determinations, a health carrier shall make the determination within thirty-six
43 hours, which shall include one working day, of obtaining all necessary information regarding a
44 proposed admission, procedure or service requiring a review determination. For purposes of this
45 section, "necessary information" includes the results of any face-to-face clinical evaluation or
46 second opinion that may be required:

47 (1) In the case of a determination to certify an admission, procedure or service, the carrier
48 shall notify the provider rendering the service by telephone or electronically within twenty-four
49 hours of making the ~~[initial]~~ certification, and provide written or electronic confirmation of a

1 telephone or electronic notification to the enrollee and the provider within two working days of
2 making the [initial] certification;

3 (2) In the case of an adverse determination, the carrier shall notify the provider rendering
4 the service by telephone or electronically within twenty-four hours of making the adverse
5 determination; and shall provide written or electronic confirmation of a telephone or electronic
6 notification to the enrollee and the provider within one working day of making the adverse
7 determination.

8 3. For concurrent review determinations, a health carrier shall make the determination
9 within one working day of obtaining all necessary information:

10 (1) In the case of a determination to certify an extended stay or additional services, the
11 carrier shall notify by telephone or electronically the provider rendering the service within one
12 working day of making the certification, and provide written or electronic confirmation to the
13 enrollee and the provider within one working day after telephone or electronic notification. The
14 written notification shall include the number of extended days or next review date, the new total
15 number of days or services approved, and the date of admission or initiation of services;

16 (2) In the case of an adverse determination, the carrier shall notify by telephone or
17 electronically the provider rendering the service within twenty-four hours of making the adverse
18 determination, and provide written or electronic notification to the enrollee and the provider within
19 one working day of a telephone or electronic notification. The service shall be continued without
20 liability to the enrollee until the enrollee has been notified of the determination.

21 4. For retrospective review determinations, a health carrier shall make the determination
22 within thirty working days of receiving all necessary information. A carrier shall provide notice in
23 writing of the carrier's determination to an enrollee within ten working days of making the
24 determination.

25 5. A written notification of an adverse determination shall include the principal reason or
26 reasons for the determination, including the clinical rationale, and the instructions for initiating an
27 appeal or reconsideration of the determination~~], and the instructions for requesting a written~~
28 ~~statement of the clinical rationale, including the clinical review criteria used to make the~~
29 ~~determination]~~. A health carrier shall provide the clinical rationale in writing for an adverse
30 determination, including the clinical review criteria used to make that determination, to the health
31 care provider and to any party who received notice of the adverse determination ~~[and who requests~~
32 ~~such information]~~.

33 6. A health carrier shall have written procedures to address the failure or inability of a
34 provider or an enrollee to provide all necessary information for review. These procedures shall be
35 made available to health care providers on the health carrier's website or provider portal. In cases
36 where the provider or an enrollee will not release necessary information, the health carrier may deny
37 certification of an admission, procedure or service.

38 7. Provided the patient is an enrollee of the health benefit plan, no utilization review entity
39 shall revoke, limit, condition, or otherwise restrict a prior authorization within forty-five working
40 days of the date the health care provider receives the prior authorization.

41 8. Provided the patient is an enrollee of the health benefit plan at the time the service is
42 provided, no health carrier, utilization review entity, or health care provider shall bill an enrollee for
43 any health care service for which a prior authorization was in effect at the time the health care
44 service was provided, except as consistent with cost-sharing requirements applicable to a covered
45 benefit under the enrollee's health benefit plan. Such cost-sharing shall be subject to and applied
46 toward any in-network deductible or out-of-pocket maximum applicable to the enrollee's health
47 benefit plan.

48 376.1364. 1. Any utilization review entity performing prior authorization review shall
49 provide a unique confirmation number to a provider upon receipt from that provider of a request for

1 prior authorization. Except as otherwise requested by the provider in writing, unique confirmation
 2 numbers shall be transmitted or otherwise communicated through the same medium through which
 3 the requests for prior authorization were made.

4 2. No later than January 1, 2021, utilization review entities shall accept and respond to
 5 requests for prior authorization of drug benefits through a secure electronic transmission using the
 6 National Council for Prescription Drugs SCRIPT Standard Version 2017071 or a backwards-
 7 compatible successor adopted by the United States Department of Health and Human Services. For
 8 purposes of this subsection, facsimile, proprietary payer portals, and electronic forms shall not be
 9 considered electronic transmission.

10 3. No later than January 1, 2021, utilization review entities shall accept and respond to
 11 requests for prior authorization of health care services and mental health services electronically. For
 12 purposes of this subsection, facsimile, proprietary payer portals, and electronic forms shall not be
 13 considered electronic transmission.

14 4. No later than January 1, 2021, each health carrier utilizing prior authorization review
 15 shall develop a single secure electronic prior authorization cover page for all of its health benefit
 16 plans utilizing prior authorization review, which the carrier or its utilization review entity shall use
 17 to accept and respond to, and which providers shall use to submit, requests for prior authorization.
 18 Such cover page shall include, but not be limited to, fields for patient or enrollee information,
 19 referring or requesting provider information, rendering or attending provider information, and
 20 required clinical information, and shall be supplemented by additional clinical information as
 21 required by the health carrier or utilization review entity.

22 376.1372. 1. In the certificate of coverage and the member handbook provided to enrollees,
 23 a health carrier shall include a clear and comprehensive description of its utilization review
 24 procedures, including the procedures for obtaining review of adverse determinations, and a
 25 statement of rights and responsibilities of enrollees with respect to those procedures.

26 2. A health carrier shall include a summary of its utilization review procedures in material
 27 intended for prospective enrollees.

28 3. A health carrier shall print on its membership cards a toll-free telephone number to call
 29 for utilization review decisions.

30 4. (1) A health carrier or utilization review entity shall make any current prior authorization
 31 requirements or restrictions, including written clinical review criteria, readily accessible on its
 32 website or provider portal. Requirements and restrictions, including step therapy protocols as such
 33 term is defined in section 376.2030, shall be described in detail.

34 (2) No health carrier or utilization review entity shall amend or implement a new prior
 35 authorization requirement or restriction prior to the change being reflected on the carrier or
 36 utilization review entity's website or provider portal as specified in subdivision (1) of this
 37 subsection.

38 (3) Health carriers and utilization review entities shall provide participating providers with
 39 written or electronic notice of the new or amended requirement not less than sixty days prior to
 40 implementing the requirement or restriction.

41 376.1385. 1. Upon receipt of a request for second-level review, a health carrier shall submit
 42 the grievance to a grievance advisory panel consisting of:

43 (1) Other enrollees;

44 (2) Representatives of the health carrier that were not involved in the circumstances giving
 45 rise to the grievance or in any subsequent investigation or determination of the grievance; and

46 (3) Where the grievance involves an adverse determination, a majority of persons that are
 47 [appropriate] clinical peers licensed to practice in the same or similar specialty as would typically
 48 manage the case being reviewed that were not involved in the circumstances giving rise to the
 49 grievance or in any subsequent investigation or determination of the grievance.

1 2. Review by the grievance advisory panel shall follow the same time frames as a first level
2 review, except as provided for in section 376.1389 if applicable. Any decision of the grievance
3 advisory panel shall include notice of the enrollee's or the health carrier's or plan sponsor's rights to
4 file an appeal with the director's office of the grievance advisory panel's decision. The notice shall
5 contain the toll-free telephone number and address of the director's office."; and

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