

FIRST REGULAR SESSION

HOUSE BILL NO. 708

99TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE HILL.

0843H.011

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 376.385, 376.429, 376.446, 376.779, 376.781, 376.811, 376.845, 376.1192, 376.1199, 376.1200, 376.1215, 376.1218, 376.1219, 376.1220, 376.1224, 376.1225, 376.1230, 376.1232, 376.1235, 376.1237, 376.1250, 376.1253, 376.1275, 376.1400, 376.1550, and 376.1900, RSMo, and to enact in lieu thereof twenty-seven new sections relating to short-term major medical policies.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 376.385, 376.429, 376.446, 376.779, 376.781, 376.811, 376.845, 2 376.1192, 376.1199, 376.1200, 376.1215, 376.1218, 376.1219, 376.1220, 376.1224, 376.1225, 3 376.1230, 376.1232, 376.1235, 376.1237, 376.1250, 376.1253, 376.1275, 376.1400, 376.1550, 4 and 376.1900, RSMo, are repealed and twenty-seven new sections enacted in lieu thereof, to be 5 known as sections 376.008, 376.385, 376.429, 376.446, 376.779, 376.781, 376.811, 376.845, 6 376.1192, 376.1199, 376.1200, 376.1215, 376.1218, 376.1219, 376.1220, 376.1224, 376.1225, 7 376.1230, 376.1232, 376.1235, 376.1237, 376.1250, 376.1253, 376.1275, 376.1400, 376.1550, 8 and 376.1900, to read as follows:

376.008. All short-term major medical policies sold in this state shall include on any 2 application for coverage and on the fact page of all policies a conspicuous and clearly 3 captioned paragraph stating that, “this policy does not satisfy the individual mandate of 4 the Affordable Care Act and you may be subject to the individual shared responsibility 5 payment fee”.

376.385. 1. Each entity offering individual and group health insurance policies 2 providing coverage on an expense-incurred basis, individual and group service or indemnity type 3 contracts issued by a health services corporation, individual and group service contracts issued

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

4 by a health maintenance organization, all self-insured group arrangements, to the extent not
5 preempted by federal law, and all managed health care delivery entities of any type or
6 description, that are delivered, issued for delivery, continued or renewed in this state on or after
7 January 1, 1998, shall offer coverage for all physician-prescribed medically appropriate and
8 necessary equipment, supplies and self-management training used in the management and
9 treatment of diabetes. Coverage shall include persons with gestational, type I or type II diabetes.

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

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

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

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

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

16 3. Coverage required by this section shall include coverage for routine patient care costs
17 incurred for drugs and devices that have been approved for sale by the Food and Drug
18 Administration (FDA), regardless of whether approved by the FDA for use in treating the
19 patient's particular condition, including coverage for reasonable and medically necessary services
20 needed to administer the drug or use the device under evaluation in the clinical trial.

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

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

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

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

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

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

- 50 (1) "Cooperative group", a formal network of facilities that collaborate on research
51 projects and have an established NIH-approved Peer Review Program operating within the
52 group, including the NCI Clinical Cooperative Group and the NCI Community Clinical
53 Oncology Program;
- 54 (2) "Multiple project assurance contract", a contract between an institution and the
55 federal Department of Health and Human Services (DHHS) that defines the relationship of the

56 institution to the DHHS and sets out the responsibilities of the institution and the procedures that
57 will be used by the institution to protect human subjects;

58 (3) "Routine patient care costs" shall include coverage for reasonable and medically
59 necessary services needed to administer the drug or device under evaluation in the clinical trial.
60 Routine patient care costs include all items and services that are otherwise generally available
61 to a qualified individual that are provided in the clinical trial except:

62 (a) The investigational item or service itself;

63 (b) Items and services provided solely to satisfy data collection and analysis needs and
64 that are not used in the direct clinical management of the patient; and

65 (c) Items and services customarily provided by the research sponsors free of charge for
66 any enrollee in the trial.

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

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

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

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

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

9 2. This section shall not apply to a supplemental insurance policy, including a life care
10 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
11 benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care

12 policy, short-term major medical policy [~~of six months or less duration~~] **having a duration of**
13 **less than one year**, or any other supplemental policy.

14 3. The provisions of subsections 1 and 2 shall become effective on January 1, 2014.

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

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

28 3. The department of mental health may issue rules necessary to carry out the provisions
29 of this section. No rule or portion of a rule promulgated under the authority of this section shall
30 become effective unless it has been promulgated pursuant to the provisions of section 536.024.

31 4. All substance abuse treatment programs in Missouri receiving funding from the
32 Missouri department of mental health must be certified by the department.

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

 376.781. 1. All group health insurance policies providing coverage on an
2 expense-incurred basis, all group service or indemnity contracts issued by a not-for-profit health
3 service corporation, all self-insured group health benefit plans of any type or description, and all
4 such health plans or policies that are individually underwritten or provide for such coverage for
5 specific individuals and the members of their families as nongroup policies, which provide for
6 hospital treatment, shall offer coverage for the necessary care and treatment of loss or
7 impairment of speech or hearing subject to the same durational limits, dollar limits, deductibles
8 and coinsurance factors as other covered services in such policies or contracts. All Missouri
9 group contracts issued or renewed on or after December 31, 1984, shall be subject to this section.
10 Notwithstanding any construction or relationship of interdependent contracts or plans affecting
11 coverage and payment of reimbursement prerequisites under the policy or contract, coverage
12 required by this section shall be included in the policy or contract and payment provided as for
13 other coverage in the same policy or contract.

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

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

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

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

28 6. The department of insurance, financial institutions and professional registration may
29 issue rules necessary to carry out the provisions of this section. No rule or portion of a rule

30 promulgated under the authority of this section shall become effective unless it has been
31 promulgated pursuant to the provisions of section 536.024.

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

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

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

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

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

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

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

22 (c) May deliver covered services through a system of contractual arrangements with one
23 or more providers, hospitals, nonresidential or residential treatment programs, or other mental
24 health service delivery entities certified by the department of mental health, or accredited by a
25 nationally 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
29 illness, 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
32 licensed professional to the same extent as any other illness;

33 (2) Coverage for residential treatment programs for the therapeutic care and treatment
34 of a recognized mental illness when prescribed by a licensed professional and rendered in a
35 psychiatric residential treatment center licensed by the department of mental health or accredited
36 by the Joint 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,
40 co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical
41 illness; and

42 (5) The coverages set forth in this subsection may be administered pursuant to a
43 managed care program established by the insurance company, health services corporation or
44 health maintenance organization, and covered services may be delivered through a system of
45 contractual arrangements with one or more providers, community mental health centers,
46 hospitals, nonresidential or residential treatment programs, or other mental health service
47 delivery entities certified by the department of mental health, or accredited by a nationally
48 recognized organization, or licensed by the state of Missouri.

49 3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the
50 group or individual policyholder or contract holder and, if accepted, shall fully and completely
51 satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to
52 376.814 shall prohibit an insurance company, health services corporation or health maintenance
53 organization from including all or part of the coverages set forth in sections 376.810 to 376.814
54 as standard coverage in their policies or contracts issued in this state.

55 4. Every insurance company, health services corporation and health maintenance
56 organization doing business in this state shall offer in all health insurance policies mental health
57 benefits or coverage as part of the policy or as a supplement to the policy. Such mental health
58 benefits or coverage shall include at least two sessions per year to a licensed psychiatrist,
59 licensed psychologist, licensed professional counselor, licensed clinical social worker, or, subject
60 to contractual provisions, a licensed marital and family therapist, acting within the scope of such
61 license and under the following minimum standards:

62 (1) Coverage and benefits in this subsection shall be for the purpose of diagnosis or
63 assessment, but not dependent upon findings; and

64 (2) Coverage and benefits in this subsection shall not be subject to any conditions of
65 preapproval, and shall be deemed reimbursable as long as the provisions of this subsection are
66 satisfied; and

67 (3) Coverage and benefits in this subsection shall be subject to the same coinsurance,
68 co-payment and deductible factors as apply to regular office visits under coverages and benefits
69 for physical illness.

70 5. If the group or individual policyholder or contract holder rejects the offer required by
71 this section, then the coverage shall be governed by the mental health and chemical dependency
72 insurance act as provided in sections 376.825 to 376.836.

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

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

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

10 (2) "Health benefit plan", shall have the same meaning as such term is defined in section
11 376.1350; however, for purposes of this section "health benefit plan" does not include a
12 supplemental insurance policy, including a life care contract, accident-only policy, specified
13 disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy,
14 long-term care policy, short-term major medical policy [~~of six months or less duration~~] **having**
15 **a duration of less than one year**, or any other supplemental policy;

16 (3) "Health carrier", shall have the same meaning as such term is defined in section
17 376.1350;

18 (4) "Medical care", health care services needed to diagnose, prevent, treat, cure, or
19 relieve physical manifestations of an eating disorder, and shall include inpatient hospitalization,
20 partial hospitalization, residential care, intensive outpatient treatment, follow-up outpatient care,
21 and counseling;

22 (5) "Pharmacy care", medications prescribed by a licensed physician for an eating
23 disorder and includes any health-related services deemed medically necessary to determine the

24 need or effectiveness of the medications, but only to the extent that such medications are
25 included in the insured's health benefit plan;

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

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

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

40 2. In accordance with the provisions of section 376.1550, all health benefit plans that are
41 delivered, issued for delivery, continued or renewed on or after January 1, 2017, if written inside
42 the state of Missouri, or written outside the state of Missouri but covering Missouri residents,
43 shall provide coverage for the diagnosis and treatment of eating disorders as required in section
44 376.1550.

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

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

55 5. Coverage of the treatment of eating disorders may be subject to other general
56 exclusions and limitations of the contract or benefit plan not in conflict with the provisions of
57 this section, such as coordination of benefits, and utilization review of health care services,
58 which includes reviews of medical necessity and care management. Medical necessity
59 determinations and care management for the treatment of eating disorders shall consider the

60 overall medical and mental health needs of the individual with an eating disorder, shall not be
61 based solely on weight, and shall take into consideration the most recent Practice Guideline for
62 the Treatment of Patients with Eating Disorders adopted by the American Psychiatric
63 Association in addition to current standards based upon the medical literature generally
64 recognized as authoritative in the medical community.

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

3 2. Beginning September 1, 2013, the oversight division of the joint committee on
4 legislative research shall perform an actuarial analysis of the cost impact to health carriers,
5 insureds with a health benefit plan, and other private and public payers if state mandates were
6 enacted to provide health benefit plan coverage for the following:

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

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

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

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

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

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

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

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

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

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

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

5 (1) Notwithstanding the provisions of subsection 4 of section 354.618, provide enrollees
6 with direct access to the services of a participating obstetrician, participating gynecologist or
7 participating obstetrician/gynecologist of her choice within the provider network for covered
8 services. The services covered by this subdivision shall be limited to those services defined by
9 the published recommendations of the accreditation council for graduate medical education for
10 training an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to
11 diagnosis, treatment and referral for such services. A health carrier shall not impose additional
12 co-payments, coinsurance or deductibles upon any enrollee who seeks or receives health care
13 services pursuant to this subdivision, unless similar additional co-payments, coinsurance or
14 deductibles are imposed for other types of health care services received within the provider
15 network. Nothing in this subsection shall be construed to require a health carrier to perform,
16 induce, pay for, reimburse, guarantee, arrange, provide any resources for or refer a patient for an
17 abortion, as defined in section 188.015, other than a spontaneous abortion or to prevent the death
18 of the female upon whom the abortion is performed, or to supersede or conflict with section
19 376.805; and

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

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

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

35

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

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

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

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

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

58 (2) Upon request of an enrollee who is a member of a group health benefit plan and who
59 states that the use or provision of contraceptives is contrary to his or her moral, ethical or
60 religious beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that

61 excludes coverage for contraceptives. Any administrative costs to a group health benefit plan
62 associated with such exclusion of coverage not offset by the decreased costs of providing
63 coverage shall be borne by the group policyholder or group plan holder;

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

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

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

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

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

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

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

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

87

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

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

96 8. The departments of health and senior services and insurance, financial institutions and
97 professional registration may promulgate rules necessary to implement the provisions of this
98 section. No rule or portion of a rule promulgated pursuant to this section shall become effective
99 unless it has been promulgated pursuant to chapter 536. Any rule or portion of a rule, as that
100 term is defined in section 536.010, that is created under the authority delegated in this section
101 shall become effective only if it complies with and is subject to all of the provisions of chapter
102 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any
103 of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the
104 effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the
105 grant of rulemaking authority and any rule proposed or adopted after August 28, 2001, shall be
106 invalid and void.

 376.1200. 1. Each entity offering individual and group health insurance policies
2 providing coverage on an expense-incurred basis, individual and group service or indemnity type
3 contracts issued by a health services corporation, individual and group service contracts issued
4 by a health maintenance organization, all self-insured group arrangements to the extent not
5 preempted by federal law and all managed health care delivery entities of any type or description,
6 that are delivered, issued for delivery, continued or renewed in this state on or after January 1,
7 1996, shall offer coverage for the treatment of breast cancer by dose-intensive
8 chemotherapy/autologous bone marrow transplants or stem cell transplants when performed
9 pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers
10 experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell
11 transplants. The offer of benefits under this section shall be in writing and must be accepted in
12 writing by the individual or group policyholder or contract holder.

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

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

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

25 (2) Such care was not medically appropriate; or

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

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

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

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

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

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

15 4. This section shall not apply to supplemental insurance policies, including life care
16 contracts, accident-only policies, specified disease policies, hospital policies providing a fixed
17 daily benefit only, Medicare supplement policies, long-term care policies, coverage issued as a
18 supplement to liability insurance, short-term major medical policies [~~of six months or less~~
19 ~~duration~~] **having a duration of less than one year**, and other supplemental policies as
20 determined by the department of insurance, financial institutions and professional registration.

21 5. The department of health and senior services shall promulgate rules and regulations
22 to determine which immunizations shall be covered by policies, plans or contracts described in
23 this section. No rule or portion of a rule promulgated under the authority of this section shall
24 become effective unless it has been promulgated pursuant to the provisions of section 536.024.

25 6. No health care provider shall charge more than one hundred percent of the reasonable
26 and customary charges for providing any immunization.

376.1218. 1. Any health carrier or health benefit plan that offers or issues health benefit
2 plans, other than Medicaid health benefit plans, which are delivered, issued for delivery,
3 continued, or renewed in this state on or after January 1, 2006, shall provide coverage for early

4 intervention services described in this section that are delivered by early intervention specialists
5 who are health care professionals licensed by the state of Missouri and acting within the scope
6 of their professions for children from birth to age three identified by the Part C early intervention
7 system as eligible for services under Part C of the Individuals with Disabilities Education Act,
8 20 U.S.C. Section 1431, et seq. Such coverage shall be limited to three thousand dollars for each
9 covered child per policy per calendar year, with a maximum of nine thousand dollars per child.

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

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

18 4. For purposes of this section, "early intervention services" means medically necessary
19 speech and language therapy, occupational therapy, physical therapy, and assistive technology
20 devices for children from birth to age three who are identified by the Part C early intervention
21 system as eligible for services under Part C of the Individuals with Disabilities Education Act,
22 20 U.S.C. Section 1431, et seq. Early intervention services shall include services under an active
23 individualized family service plan that enhance functional ability without effecting a cure. An
24 individualized family service plan is a written plan for providing early intervention services to
25 an eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section
26 1436. The Part C early intervention system, on behalf of its contracted regional Part C early
27 intervention system centers and providers, shall be considered the rendering provider of services
28 for purposes of this section.

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

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

42 7. (1) Subject to the provisions of this section, payments made during a calendar year
43 by a health carrier or group of carriers affiliated by or under common ownership or control to the
44 Part C early intervention system for services provided to children covered by the Part C early
45 intervention system shall not exceed one-half of one percent of the direct written premium for
46 health benefit plans as reported to the department of insurance, financial institutions and
47 professional registration on the health carrier's most recently filed annual financial statement.

48 (2) In lieu of reimbursing claims under this section, a carrier or group of carriers
49 affiliated by or under common ownership or control may, on behalf of all of the carrier's or
50 carriers' health benefit plan or plans providing coverage under this section, directly pay the Part
51 C early intervention system by January thirty-first of the calendar year an amount equal to
52 one-half of one percent of the direct written premium for health benefit plans as reported to the
53 department of insurance, financial institutions and professional registration on the health carrier's
54 most recently filed annual financial statement, or five hundred thousand dollars, whichever is
55 less, and such payment shall constitute full and complete satisfaction of the health benefit plan's
56 obligation for the calendar year. Nothing in this subsection shall require a health carrier or health
57 benefit plan providing coverage under this section to amend or modify any provision of an
58 existing policy or plan relating to the payment or reimbursement of claims by the health carrier
59 or health benefit plan.

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

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

73 10. Notwithstanding the provisions of section 23.253 to the contrary, the provisions of
74 this section shall not sunset.

376.1219. 1. Each policy issued by an entity offering individual and group health insurance which provides coverage on an expense-incurred basis, individual and group health 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 health arrangements to the extent not preempted by federal law, and all health care plans provided by 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 September 1, 1997, shall provide coverage for formula and low protein modified food products recommended by a physician for the treatment of a patient with phenylketonuria or any inherited disease of amino and organic acids who is covered under the policy, contract, or plan and who is less than six years of age.

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

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

4. 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 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.

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

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

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

18 4. Coverage for newborn hearing screening and any necessary rescreening and
19 audiological assessment shall be provided to newborns eligible for medical assistance pursuant
20 to section 208.151, and the children's health program pursuant to sections 208.631 to 208.660,
21 with payment for the newborn hearing screening required in section 191.925, and any necessary
22 rescreening, audiological assessment and follow-up, and amplification as described in section
23 191.928.

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

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

6 (2) "Autism service provider":

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

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

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

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

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

22 (6) "Health benefit plan", shall have the same meaning ascribed to it as in section
23 376.1350;

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

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

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

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

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

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

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

44 (a) Psychiatric care;

45 (b) Psychological care;

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

47 (d) Therapeutic care;

48 (e) Pharmacy care.

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

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

58 4. (1) Coverage provided under this section is limited to medically necessary treatment
59 that is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to
60 the powers granted under such licensed physician's or licensed psychologist's license, in
61 accordance with a treatment plan.

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

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

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

85 6. The maximum benefit limitation for applied behavior analysis described in subsection
86 5 of this section shall be adjusted by the health carrier at least triennially for inflation to reflect
87 the aggregate increase in the general price level as measured by the Consumer Price Index for
88 All Urban Consumers for the United States, or its successor index, as defined and officially
89 published by the United States Department of Labor, or its successor agency. Beginning January
90 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied
91 behavior analysis coverage adjusted for inflation in accordance with this subsection shall be
92 calculated by the director of the department of insurance, financial institutions and professional
93 registration. The director shall furnish the calculated value to the secretary of state, who shall

94 publish such value in the Missouri Register as soon after each January first as practicable, but
95 it shall otherwise be exempt from the provisions of section 536.021.

96 7. Subject to the provisions set forth in subdivision (3) of subsection 4 of this section,
97 coverage provided under this section shall not be subject to any limits on the number of visits
98 an individual may make to an autism service provider, except that the maximum total benefit for
99 applied behavior analysis set forth in subsection 5 of this section shall apply to this subsection.

100 8. This section shall not be construed as limiting benefits which are otherwise available
101 to an individual under a health benefit plan. The health care coverage required by this section
102 shall not be subject to any greater deductible, coinsurance, or co-payment than other physical
103 health care services provided by a health benefit plan. Coverage of services may be subject to
104 other general exclusions and limitations of the contract or benefit plan, not in conflict with the
105 provisions of this section, such as coordination of benefits, exclusions for services provided by
106 family or household members, and utilization review of health care services, including review
107 of medical necessity and care management; however, coverage for treatment under this section
108 shall not be denied on the basis that it is educational or habilitative in nature.

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

111 (1) The autism service provider, as defined in this section; or

112 (2) The entity or group for whom such supervising person, who is certified as a
113 board-certified behavior analyst by the Behavior Analyst Certification Board, works or is
114 associated.

115

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

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

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

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

130 (1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section
131 1002(32);

132 (2) All self-insured group arrangements, to the extent not preempted by federal law;

133 (3) All plans provided through a multiple employer welfare arrangement, or plans
134 provided through another benefit arrangement, to the extent permitted by the Employee
135 Retirement Income Security Act of 1974, or any waiver or exception to that act provided under
136 federal law or regulation; and

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

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

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

145 15. Any health carrier or other entity subject to the provisions of this section shall not
146 be required to provide reimbursement for the applied behavior analysis delivered to a person
147 insured by such health carrier or other entity to the extent such health carrier or other entity is
148 billed for such services by any Part C early intervention program or any school district for
149 applied behavior analysis rendered to the person covered by such health carrier or other entity.
150 This section shall not be construed as affecting any obligation to provide services to an
151 individual under an individualized family service plan, an individualized education plan, or an
152 individualized service plan. This section shall not be construed as affecting any obligation to
153 provide reimbursement pursuant to section 376.1218.

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

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

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

165 19. (1) By February 1, 2012, and every February first thereafter, the department of
 166 insurance, financial institutions and professional registration shall submit a report to the general
 167 assembly regarding the implementation of the coverage required under this section. The report
 168 shall include, but shall not be limited to, the following:

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

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

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

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

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

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

9 (1) A child under the age of five;

10 (2) A person who is severely disabled; or

11 (3) A person who has a medical or behavioral condition which requires hospitalization
 12 or general anesthesia when dental care is provided.

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

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

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

376.1230. 1. Every policy issued by a health carrier, as defined in section 376.1350,
 2 shall provide coverage for chiropractic care delivered by a licensed chiropractor acting within

3 the scope of his or her practice as defined in chapter 331. The coverage shall include initial
4 diagnosis and clinically appropriate and medically necessary services and supplies required to
5 treat the diagnosed disorder, subject to the terms and conditions of the policy. The coverage may
6 be limited to chiropractors within the health carrier's network, and nothing in this section shall
7 be construed to require a health carrier to contract with a chiropractor not in the carrier's network
8 nor shall a carrier be required to reimburse for services rendered by a nonnetwork chiropractor
9 unless prior approval has been obtained from the carrier by the enrollee. An enrollee may access
10 chiropractic care within the network for a total of twenty-six chiropractic physician office visits
11 per policy period, but may be required to provide the health carrier with notice prior to any
12 additional visit as a condition of coverage. A health carrier may require prior authorization or
13 notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office
14 visits for treatment in excess of twenty-six in any policy period. The certificate of coverage for
15 any health benefit plan issued by a health carrier shall clearly state the availability of chiropractic
16 coverage under the policy and any limitations, conditions, and exclusions.

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

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

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

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

376.1232. 1. Each health carrier or health benefit plan that offers or issues health benefit
2 plans which are delivered, issued for delivery, continued, or renewed in this state on or after
3 January 1, 2010, shall offer coverage for prosthetic devices and services, including original and
4 replacement devices, as prescribed by a physician acting within the scope of his or her practice.

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

7 3. The amount of the benefit for prosthetic devices and services under this section shall
8 be no less than the annual and lifetime benefit maximums applicable to the basic health care
9 services required to be provided under the health benefit plan. If the health benefit plan does not

10 include any annual or lifetime maximums applicable to basic health care services, the amount
11 of the benefit for prosthetic devices and services shall not be subject to an annual or lifetime
12 maximum benefit level. Any co-payment, coinsurance, deductible, and maximum out-of-pocket
13 amount applied to the benefit for prosthetic devices and services shall be no more than the most
14 common amounts applied to the basic health care services required to be provided under the
15 health benefit plan.

16 4. The provisions of this section shall not apply to a supplemental insurance policy,
17 including a life care contract, accident-only policy, specified disease policy, hospital policy
18 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
19 short-term major medical policies [~~of six months or less duration~~] **having a duration of less**
20 **than one year**, or any other supplemental policy as determined by the director of the department
21 of insurance, financial institutions and professional registration.

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

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

10 3. Beginning September 1, 2016, the oversight division of the joint committee on
11 legislative research shall perform an actuarial analysis of the cost impact to health carriers,
12 insureds with a health benefit plan, and other private and public payers if the provisions of this
13 section regarding occupational therapy coverage were enacted. By December 31, 2016, the
14 director of the oversight division of the joint committee on legislative research shall submit a
15 report of the actuarial findings prescribed by this section to the speaker, the president pro tem,
16 and the chairpersons of both the house of representatives and senate standing committees having
17 jurisdiction over health insurance matters. If the fiscal note cost estimation is less than the cost
18 of an actuarial analysis, the actuarial analysis requirement shall be waived.

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

376.1237. 1. Each health carrier or health benefit plan that offers or issues health benefit
2 plans which are delivered, issued for delivery, continued, or renewed in this state on or after
3 January 1, 2014, and that provides coverage for prescription eye drops shall provide coverage
4 for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period

5 without regard to a coverage restriction for early refill of prescription renewals as long as the
6 prescribing health care provider authorizes such early refill, and the health carrier or the health
7 benefit plan is notified.

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

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

12 4. The provisions of this section shall not apply to a supplemental insurance policy,
13 including a life care contract, accident-only policy, specified disease policy, hospital policy
14 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
15 short-term major medical policies [~~of six months' or less duration~~] **having a duration of less**
16 **than one year**, or any other supplemental policy as determined by the director of the department
17 of insurance, financial institutions and professional registration.

18 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
2 an expense-incurred basis, individual and group service or indemnity type contracts issued by
3 a nonprofit corporation, individual and group service contracts issued by a health maintenance
4 organization, all self-insured group arrangements to the extent not preempted by federal law and
5 all managed health care delivery entities of any type or description, that are delivered, issued for
6 delivery, continued or renewed on or after August 28, 1999, and providing coverage to any
7 resident of this state shall provide benefits or coverage for:

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

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

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

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

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

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

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

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

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

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

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

 376.1275. 1. Each health carrier or health benefit plan that offers or issues health benefit
2 plans which are delivered, issued for delivery, continued, or renewed in this state on or after
3 January 1, 2003, shall include coverage for their members for the cost for human leukocyte
4 antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR
5 antigens for utilization in bone marrow transplantation. The testing must be performed in a
6 facility which is accredited by the American Association of Blood Banks or its successors, and
7 is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended,
8 and is accredited by the American Association of Blood Banks or its successors, the College of
9 American Pathologists, the American Society for Histocompatibility and Immunogenetics
10 (ASHI) or any other national accrediting body with requirements that are substantially equivalent
11 to or more stringent than those of the College of American Pathologists. At the time of testing,
12 the person being tested must complete and sign an informed consent form which also authorizes
13 the results of the test to be used for participation in the National Marrow Donor Program. The

14 health benefit plan may limit each enrollee to one such testing per lifetime to be reimbursed at
15 a cost of no greater than seventy-five dollars by the health carrier or health benefit plan.

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

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

21 4. The provisions of this section shall not apply to a supplemental insurance policy,
22 including a life care contract, accident-only policy, specified disease policy, hospital policy
23 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
24 short-term major medical policies [~~of six months' or less duration~~] **having a duration of less**
25 **than one year**, or any other supplemental policy as determined by the director of the department
26 of insurance, financial institutions and professional registration.

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

8 2. The standardized information shall contain the following:

9 (1) The name of the insured;

10 (2) The insured's identification number;

11 (3) The date of service;

12 (4) Amount of charge;

13 (5) Explanation for any denial;

14 (6) The amount paid;

15 (7) The patient's full name;

16 (8) The name and address of the insurer; and

17 (9) The phone number to contact for questions on explanation of benefits.

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

376.1550. 1. Notwithstanding any other provision of law to the contrary, each health
2 carrier that offers or issues health benefit plans which are delivered, issued for delivery,
3 continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a

4 mental health condition, as defined in this section, and shall comply with the following
5 provisions:

6 (1) A health benefit plan shall provide coverage for treatment of a mental health
7 condition and shall not establish any rate, term, or condition that places a greater financial burden
8 on an insured for access to treatment for a mental health condition than for access to treatment
9 for a physical health condition. Any deductible or out-of-pocket limits required by a health
10 carrier or health benefit plan shall be comprehensive for coverage of all health conditions,
11 whether mental or physical;

12 (2) The coverages set forth is this subsection:

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

15 (b) May deliver covered services through a system of contractual arrangements with one
16 or more providers, hospitals, nonresidential or residential treatment programs, or other mental
17 health service delivery entities certified by the department of mental health, or accredited by a
18 nationally recognized organization, or licensed by the state of Missouri;

19 (3) A health benefit plan that does not otherwise provide for management of care under
20 the plan or that does not provide for the same degree of management of care for all health
21 conditions may provide coverage for treatment of mental health conditions through a managed
22 care organization; provided that the managed care organization is in compliance with rules
23 adopted by the department of insurance, financial institutions and professional registration that
24 assure that the system for delivery of treatment for mental health conditions does not diminish
25 or negate the purpose of this section. The rules adopted by the director shall assure that:

26 (a) Timely and appropriate access to care is available;

27 (b) The quantity, location, and specialty distribution of health care providers is adequate;
28 and

29 (c) Administrative or clinical protocols do not serve to reduce access to medically
30 necessary treatment for any insured;

31 (4) Coverage for treatment for chemical dependency shall comply with sections 376.779,
32 376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term
33 "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to
34 376.836, the term "health insurance policy" shall include group coverage.

35 2. As used in this section, the following terms mean:

36 (1) "Chemical dependency", the psychological or physiological dependence upon and
37 abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment
38 of social or occupational role functioning or both;

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

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

41 (4) "Mental health condition", any condition or disorder defined by categories listed in
42 the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for
43 chemical dependency;

44 (5) "Managed care organization", any financing mechanism or system that manages care
45 delivery for its members or subscribers, including health maintenance organizations and any
46 other similar health care delivery system or organization;

47 (6) "Rate, term, or condition", any lifetime or annual payment limits, deductibles,
48 co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits,
49 and any other financial component of a health benefit plan that affects the insured.

50 3. This section shall not apply to a health plan or policy that is individually underwritten
51 or provides such coverage for specific individuals and members of their families pursuant to
52 section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836, a supplemental
53 insurance policy, including a life care contract, accident-only policy, specified disease policy,
54 hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care
55 policy, hospitalization-surgical care policy, short-term major medical policies [~~of six months or~~
56 ~~less duration~~] **having a duration of less than one year**, or any other supplemental policy as
57 determined by the director of the department of insurance, financial institutions and professional
58 registration.

59 4. Notwithstanding any other provision of law to the contrary, all health insurance
60 policies that cover state employees, including the Missouri consolidated health care plan, shall
61 include coverage for mental illness. Multiyear group policies need not comply until the
62 expiration of their current multiyear term unless the policyholder elects to comply before that
63 time.

64 5. The provisions of this section shall not be violated if the insurer decides to apply
65 different limits or exclude entirely from coverage the following:

66 (1) Marital, family, educational, or training services unless medically necessary and
67 clinically appropriate;

68 (2) Services rendered or billed by a school or halfway house;

69 (3) Care that is custodial in nature;

70 (4) Services and supplies that are not immediately nor clinically appropriate; or

71 (5) Treatments that are considered experimental.

72 6. The director shall grant a policyholder a waiver from the provisions of this section if
73 the policyholder demonstrates to the director by actual experience over any consecutive
74 twenty-four-month period that compliance with this section has increased the cost of the health
75 insurance policy by an amount that results in a two percent increase in premium costs to the

76 policyholder. The director shall promulgate rules establishing a procedure and appropriate
77 standards for making such a demonstration. Any rule or portion of a rule, as that term is defined
78 in section 536.010, that is created under the authority delegated in this section shall become
79 effective only if it complies with and is subject to all of the provisions of chapter 536 and, if
80 applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the
81 powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective
82 date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of
83 rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid
84 and void.

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

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

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

9 (3) "Health care provider" shall have the same meaning ascribed to it in section
10 376.1350;

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

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

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

15 2. Each health carrier or health benefit plan that offers or issues health benefit plans
16 which are delivered, issued for delivery, continued, or renewed in this state on or after January
17 1, 2014, shall not deny coverage for a health care service on the basis that the health care service
18 is provided through telehealth if the same service would be covered if provided through
19 face-to-face diagnosis, consultation, or treatment.

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

23 4. A health carrier shall not be required to reimburse a telehealth provider or a consulting
24 provider for site origination fees or costs for the provision of telehealth services; however,
25 subject to correct coding, a health carrier shall reimburse a health care provider for the diagnosis,
26 consultation, or treatment of an insured or enrollee when the health care service is delivered

27 through telehealth on the same basis that the health carrier covers the service when it is delivered
28 in person.

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

32 6. A health carrier shall not impose upon any person receiving benefits under this section
33 any co-payment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime,
34 or other durational benefit limitation or maximum for benefits or services that is not equally
35 imposed upon all terms and services covered under the policy, contract, or health benefit plan.

36 7. Nothing in this section shall preclude a health carrier from undertaking utilization
37 review to determine the appropriateness of telehealth as a means of delivering a health care
38 service, provided that the determinations shall be made in the same manner as those regarding
39 the same service when it is delivered in person.

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

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

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

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