CCS HCS SS SB 262 -- HEALTH INSURANCE

This bill changes the laws regarding health insurance.

MISSOURI ORAL CHEMOTHERAPY PARITY INTERIM COMMITTEE (Section 338.321, RSMo)

The Missouri Oral Chemotherapy Parity Interim Committee is established to study the disparity in patient co-payments between orally and intravenously administered chemotherapies, the reasons for the disparity, and the patient benefits in establishing co-payment parity between oral and infused chemotherapy agents. The committee must consider information on the costs or actuarial analysis associated with the delivery of patient oncology treatments.

The committee must consist of the following members:

(1) Two members of the Senate appointed by the President Pro Tem of the Senate;

(2) Two members of the House of Representatives appointed by the Speaker of the House of Representatives;

(3) One member who is an oncologist or physician with expertise in the practice of oncology licensed in this state under Chapter 334;

(4) One member who is an oncology nurse licensed in this state under Chapter 335;

(5) One member who is a representative of a Missouri pharmacy benefit management company;

(6) One member from an organization representing licensed pharmacists in this state;

(7) One member from the business community representing businesses on health insurance issues;

(8) One member from an organization representing the leading research-based pharmaceutical and biotechnology companies;

(9) One patient advocate;

(10) One member from the organization representing a majority of hospitals in this state;

(11) One member from a health carrier as the term is defined under Section 376.1350;

(12) One member from the organization representing a majority of health carriers in this state as the term is defined under Section 376.1350;

(13) One member from the American Cancer Society; and

(14) One member from an organization representing generic pharmaceutical drug manufacturers.

All members, except for the members from the General Assembly, are to be appointed by the Governor by September 1, 2013. The Department of Insurance, Financial Institutions and Professional Registration must provide assistance to the committee. By January 1, 2014, the committee must submit a report to the Governor, Speaker of the House of Representatives, President Pro Tem of the Senate, and the appropriate legislative committees of the General Assembly regarding the results of the study and any legislative recommendations.

HEALTH INSURANCE COVERAGE (Sections 354.410 - 354.430)

The bill:

(1) Specifies that the powers of a health maintenance organization include the power to offer as an option at least one health benefit plan that contains deductibles, coinsurance, coinsurance differentials, or variable co-payments. The plan must be permitted only when combined with a specified health savings or health reimbursement account that meets specified conditions; and

(2) Requires a statement or summary of evidence of coverage to include any limitations on the services, kinds of services, benefits, or kinds of benefits to be provided, including coinsurance or other cost-sharing feature as requested by the group contract holder or in the case of non-group coverage, the individual certificate holder.

EXCLUSIVE NETWORK PLANS (Section 376.325)

A health carrier with a closed or exclusive provider network must accept into the network any willing licensed physician who agrees to accept a fee schedule, payment, or reimbursement rate that is 15% less than the health carrier's standard prevailing or market fee schedule, payment, or reimbursement rate for the network in the geographic area of the licensed physician's practice. These provisions do not apply to any licensed physician who does not meet the health carrier's selection standards and credentialing criteria or who has not entered into the carrier's standard participating

provider agreement.

POLICY FORM APPROVAL PROCESS (Sections 376.405 and 376.777)

The Director of the Department of Insurance, Financial Institutions and Professional Registration is authorized to make reasonable rules and regulations concerning the filing and submission of policies, including the disapproval of policies. The bill specifies that if a policy form is disapproved, all specific reasons for nonconformance must be stated in writing within 45 days from the date of filing, and the department director must approve or disapprove a submitted policy within 45 days, instead of the current 60 days, from the date of filing or the policy will be considered approved. If the department director determines at any time after a policy form is approved or deemed approved that any provision of the filing is contrary to state law, he or she must notify the carrier of the specific provisions and any specific statute or regulation in conflict with the provision and request that the carrier file an amendment form to modify it within 30 days. Upon approval of the amendment form by the department director, the health carrier must issue a copy of the amendment to every individual and entity to which the filing was issued. The amendment must have the force and effect as if it was in the original filing or policy.

MANAGED CARE PLANS (Sections 376.426 and 376.777)

A health carrier may offer a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services and certain chemical dependency treatments, and requires the health carrier to disclose this provision in clear, conspicuous, and understandable language in the enrollment application and the policy form. If a health carrier offers a managed care health benefit plan to a group contract holder as an exclusive or full replacement health benefit plan, the health carrier must offer at least one additional health benefit plan option that includes an out-of-network benefit. The decision to accept or reject the offer of the optional health benefit plan must be made by the enrollee and not the group contract holder. The health benefit plan must have a procedure by which an enrollee may obtain a referral to a nonparticipating provider when he or she is diagnosed with a life-threatening condition or disabling degenerative disease.

MISSOURI HEALTH INSURANCE POOL (Sections 376.961 - 376.973)

The bill:

(1) Specifies that beginning August 28, 2013, the board of

directors, on behalf of the Missouri Health Insurance Pool, the executive director, and any other employees of the pool will have the authority to provide assistance or resources to any department, agency, public official, employee, or agent of the federal government for the specific purpose of transitioning individuals enrolled in the pool to coverage outside of the pool beginning on or before January 1, 2014. This authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange. By September 1, 2013, the board must submit the amendments to the plan of operation as are necessary or suitable to ensure a reasonable transition period to allow for the termination of the issuance of policies by the pool. The amendments must include all current requirements under Section 376.962.2, including the selection of an administering insurer or third-party administrator, and must address the transition of individuals covered under the pool to alternative health insurance coverage as it is available after January 1, 2014. The plan of operation must also address procedures for finalizing the financial matters of the pool, including assessments, claims expenses, and other specified matters. The department director must review the plan of operation and establish rules to effectuate the transitional plan of operation. The rules must be effective by October 1, 2013;

(2) Allows, prior to January 1, 2014, the board of directors and administering insurers to issue policies of insurance from the pool. A new insurance policy cannot be issued on or after January 1, 2014. All coverage under the pool must expire on January 1, 2014;

(3) Requires, by September 1, 2013, the board to invite all insurers and third-party administrators, including the current administering insurer, to submit bids to serve as the administering insurer or third-party administrator for the pool. The selection of the administering insurer or third-party administrator must be made prior to January 1, 2014. Beginning January 1, 2014, the administering insurer or third-party administrator must:

(a) Submit to the board and the department director a detailed plan outlining the winding down of operations of the pool. The plan must be submitted no later than January 31, 2014, and updated quarterly thereafter;

(b) Perform all administrative claim-payment functions relating to the pool;

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool, including making available information on the proper manner of submitting a claim

for benefits to the pool, distributing forms on which submissions must be made, and evaluating the eligibility of each claim for payment by the pool;

(d) Submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report must be determined by the board;

(e) Determine, following the close of each calendar year, the expense of administration and the paid and incurred losses for the year and report the information to the board and department on a form prescribed by the department director; and

(f) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services; and

(4) Requires pool assessments to continue until the executive director of the pool notifies the board and the department director that all claims have been paid. Any assessment funds remaining at the time that all claims have been paid must be deposited in the General Revenue Fund.

ACTUARIAL ANALYSIS

The bill requires, beginning September 1, 2013, the Oversight Division of the Joint Committee on Legislative Research to conduct an actuarial analysis of the cost impact to health carriers, insureds with a health benefit plan, and other private and public payers if state mandates were enacted to provide health benefit plan coverages for the following:

(1) Orally administered anticancer medication charged at the same co-payment or deductible as intravenously administered or injected cancer medication; and

(2) Diagnosis and treatment of eating disorders, including residential treatment and access to psychiatric and medical treatments.

By December 31, 2013, the division director must submit a report of the actuarial findings to the Speaker of the House of Representatives; President Pro Tem of the Senate; and the chairs of the House Committee on Health Insurance and the Senate Small Business, Insurance and Industry Committee or the committees having jurisdiction over health insurance issues if the committees no longer exist. The actuarial analysis must assume that the mandated coverage will not be subject to any greater deductible or co-payment than other health care services provided by the health benefit plan and will not apply to a supplemental insurance policy.

The cost for each analysis cannot exceed $30,000, and the joint committee may utilize any actuary contracted to perform services for the Missouri Consolidated Health Care Plan to perform the required analysis.

UTILIZATION REVIEW PROCEDURE (Section 376.1363)

The bill allows a health carrier to electronically contact enrollees and providers acting on behalf of enrollees in the case of a determination or adverse determination to certify an admission, procedure, service, extended stay, or additional services. Currently, a carrier must make the notification by telephone.

HEALTH CARE PROVIDER CREDENTIALING (Sections 376.1575 and 376.1578)

Within two working days after receipt of a faxed or mailed completed application seeking authorization to provide patient care services, a health carrier must send a notice of receipt to the practitioner. A health carrier must provide access to a provider Internet portal that allows a practitioner to receive notice of the status of an electronically submitted application. A health carrier must assess a practitioner's credentialing information and approve or deny the application within 60 business days of receipt of the completed application. The deadline must not apply if the application or subsequent verification information indicates that the practitioner has a history of behavioral disorders or other impairments affecting his or her ability to practice, including substance abuse; has had any disciplinary actions against his or her license imposed by any state, territory, or foreign jurisdiction; has had his or her hospital admitting or surgical privileges or other credentials or authority to practice revoked, restricted, or suspended based on his or her clinical performance; or has had a judgment or judicial award against him or her arising from a medical malpractice liability lawsuit. The Department of Insurance, Financial Institutions and Professional Registration must establish a mechanism for reporting alleged violations of these provisions to the department.

TELEHEALTH HEALTH INSURANCE COVERAGE (Section 376.1900)

The bill prohibits a health carrier or health benefit plan issuing or renewing a health benefit plan on or after January 1, 2014, from denying coverage for a health care service on the basis that the service was provided through telehealth if the same service would be covered when delivered in person. A health care service cannot be excluded from coverage solely because the service is provided through telehealth rather than in person. A health carrier cannot be required to reimburse a telehealth provider or a consulting

provider for site origination fees or costs of telehealth services but, subject to correct coding, must reimburse a telehealth provider for the diagnosis, consultation, or treatment of an insured person delivered through telehealth on the same basis that the health carrier covers the service when it is delivered in person. A health care service provided through a telehealth service must not be subject to any greater deductible, co-payment, or co-insurance amount than would be applicable if the same service was provided in person. A health carrier may undertake utilization review to determine the appropriateness of telehealth as a means of delivering a health care service as long as the determinations are made in the same manner as those regarding the same service when it is delivered in person. A health carrier must not impose durational benefit limits or maximums that are not equally imposed on all terms and services covered under the plan. A health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier. A health care provider is not required to be physically present with the patient unless the provider determines that the presence of a health provider is necessary. The bill does not apply to specified types of supplemental insurance policies.

HEALTH INSURANCE MARKETPLACE INNOVATION ACT OF 2013 (Sections 376.2000 - 376.2014 and Section 1)

The Health Insurance Marketplace Innovation Act of 2013 is established, which:

(1) Defines a "navigator" as person who, for compensation, provides information or services in connection with eligibility, enrollment, or program specifications of any health benefit exchange operating in Missouri. This includes any person selected to perform the activities and duties identified in 42 U.S.C. 18031(i) in this state, any person who receives funds from the United States Department of Health and Human Services to perform any of the activities and duties identified in 42 U.S.C. 18031(i), any other person certified by the United States Department of Health and Senior Services, or a health benefit exchange operating in Missouri to perform the defined or related duties whether or not the person is identified as a navigator, certified application counselor, in-person assister, or other title. A navigator does not include any not-for-profit entity disseminating public health information to a general audience;

(2) Requires an individual or entity to be licensed as a navigator by the Department of Insurance, Financial Institutions and Professional Registration before performing, offering to perform, or advertising any service as a navigator or receiving navigator

funding from the state or an exchange;

(3) Allows a navigator to:

(a) Provide fair and impartial information and services in connection with eligibility, enrollment, and program specifications of any health benefit exchange operating in Missouri, including information about the costs of coverage, advance payments of premium tax credits, and cost sharing reductions;

(b) Facilitate the selection of a qualified health plan;

(c) Initiate the enrollment process;

(d) Provide referrals to any applicable office of health insurance consumer assistance, ombudsman, or other agency for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or determination under the plan; and

(e) Use culturally and linguistically appropriate language to communicate the information authorized in these provisions;

(4) Prohibits a navigator from engaging in the following activities unless the navigator is properly licensed as an insurance producer in this state with specified authority:

(a) Selling, soliciting, or negotiating health insurance;

(b) Engaging in any activity that would require an insurance producer license;

(c) Providing advice concerning the benefits, terms, and features of a particular health plan or offering advice about which plan is better or worse for an individual or employer;

(d) Recommending or endorsing a particular health plan or advising consumers about which plan to choose; or

(e) Providing any information or services related to health benefit plans or other products not offered in the exchange;

(5) Exempts the following entities and persons from being required to be licensed as a navigator:

(a) An entity or person licensed as an insurance producer in Missouri with authority for health under Section 375.014;

(b) A law firm or attorney licensed in Missouri; and

(c) A health care provider if the provider does not receive any moneys from the United States Department of Health and Human Services or a health exchange operating in this state to act as a navigator and the activities or functions performed are related to advising, assisting, or counseling patients regarding private or public coverage or financial matters related to medical treatments or government assistance programs. These provisions cannot prohibit a health care provider from voluntarily becoming licensed as a navigator;

(6) Requires an individual applying for a navigator license to apply on a form developed by the department director and declare under penalty of refusal, suspension, or revocation of license that the statements made in the application are true, correct, and complete to the best of his or her knowledge and belief;

(7) Requires, before approving an application, the director to determine that an individual is 18 years old or older; resides in Missouri or maintains his or her principal place of business in Missouri; is not disqualified for having committed any act that would be grounds for refusal to issue, renew, suspend, or revoke an insurance producer license; has successfully passed the written examination; has identified the entity with which he or she is affiliated and supervised; has paid the required fees; and if applicable, has received the written consent of the department director concerning crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce;

(8) Requires any entity that acts as a navigator, supervises navigators, or receives funding to do either activity to obtain a navigator entity license;

(9) Allows the department director to require any necessary documents to verify the information contained in an application by an entity or individual;

(10) Requires an entity licensed as a navigator to provide the department director with a list of all individual navigators employed by or affiliated with the entity and to report any changes in employment or affiliation within 20 days of the change;

(11) Requires the department director to provide initial training, continuing education, and written examination standards and requirements for navigators prior to an exchange becoming operational;

(12) Specifies that a navigator license will be valid for two years. To renew the license, the navigator must comply with any continuing education and ongoing training requirements and provide

proof of its completion. A navigator who fails to timely file his or her renewal will be charged a late fee in an amount prescribed by the department director;

(13) Requires a navigator to advise a person to consult with a licensed insurance producer regarding coverage in the private market if the person acknowledges having existing health insurance coverage through another insurance producer;

(14) Allows the department director to suspend, revoke, place on probation, or refuse to issue, renew, or reinstate a navigator license or to levy a fine of up to $1,000 per violation for specified offenses and requires him or her to provide, if a license is denied or not renewed, written notice of the reason. An appeal of the nonrenewal or denial must be made to the Administrative Hearing Commission;

(15) Allows the department director to issue administrative orders and maintain a civil action for relief if he or she believes a person is or was violating or materially aiding someone in violating these provisions. A violation is a level two violation under the state insurance code;

(16) Requires a navigator to report to the department director within 30 days of the final disposition of any administrative action against him or her and within 30 days of the initial pretrial hearing date in any criminal prosecution of him or her in any jurisdiction. An entity acting as a navigator that terminates the employment, engagement, affiliation, or other relationship with an individual navigator must notify the department director within 20 days of the effective date of the termination;

(17) Specifies that the requirements of Sections 379.930 to 379.952 and Chapters 375, 376, and 407 and any related rules must apply to a navigator and the activities and duties of a navigator must be deemed to be transacting the business of insurance; and

(18) Requires the department to exercise its authority and responsibility over health insurance product form filings, consumer complaints, and investigations into compliance with state law regardless of how a product may be sold or marketed in this state or to its residents.

The provisions of the bill regarding managed care plans in Section 376.426 will expire and be null and void at the end of the year following the repeal of 42 U.S.C. Section 300gg by the United States Congress or at the end of the year following a finding by a court that the provisions are unconstitutional or otherwise infirm.

The provisions of the bill regarding the licensing of navigators are severable and if any provision of the act or its application is held invalid by a court, the invalidity will not affect other provisions or applications and the remaining provisions or applications will remain in full force and effect.

The provisions of the bill regarding the actuarial analysis for specified health benefit plan coverages will expire December 31, 2013.

The provisions of the bill regarding health care provider credentialing and telehealth health insurance coverage become effective January 1, 2014.

The provisions of the bill regarding the Health Insurance Marketplace Innovation Act of 2013 contain an emergency clause.