HCS SS SB 498 -- HEALTH INSURANCE

SPONSOR: Schaefer (Molendorp)

COMMITTEE ACTION: Voted "Do Pass" by the Committee on Health Insurance by a vote of 8 to 2.

This bill changes the laws regarding health insurance.

FEE FOR CRIMINAL HISTORY CHECK (Section 43.530, RSMo)

The bill requires the Department of Public Safety to charge a fee of $14 to the Department of Insurance, Financial Institutions and Professional Registration for each criminal history check requested for a health insurance navigator license applicant.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (Sections 208.631 to 208.646)

Currently, the state children's health insurance program (SCHIP) defines uninsured children as an individual up to 19 years of age who meets specified criteria and whose parent or guardian has not had access to affordable health care coverage for their children for six months prior to application for the SCHIP. This bill removes the requirement that they be uninsured for six months. The bill changes the requirements of a parent or guardian of uninsured children eligible for SCHIP by removing the requirement that the parent or guardian demonstrate annually that their total net worth does not exceed $250,000 in total value. The bill decreases the time a child is ineligible for SCHIP coverage when a parent or guardian's income is over 250% of the Federal Poverty Level from six months to 90 days.

SHOW-ME HEALTHY BABIES PROGRAM (Section 208.662)

The bill establishes the Show-Me Healthy Babies Program within the Department of Social Services as a separate children's health insurance program for any low-income unborn child.

For an unborn child to be eligible for enrollment in the program, the mother of the child must not be eligible for coverage under Title XIX of the federal Social Security Act or the Medicaid Program as administered by the state and must not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. The unborn child must be in a family with income eligibility of no more than 300% of the federal poverty level or the equivalent modified adjusted gross income unless the income eligibility is set lower by the General Assembly through

appropriations. When calculating family size as it relates to income eligibility, the family must include in addition to other family members, the unborn child, or in the case of a mother with a multiple pregnancy, all unborn children.

Coverage for an unborn child enrolled in the program must include all prenatal care and pregnancy-related services that benefit the health of the unborn child and promote healthy labor, delivery, and birth. Coverage does not need to include services that are solely for the benefit of the pregnant mother, are unrelated to maintaining or promoting a healthy pregnancy, and provide no benefit to the unborn child.

The bill specifies that there must not be a waiting period before an unborn child may be enrolled in the program. Coverage must include the period from conception to birth and the department must develop a presumptive eligibility procedure for enrolling an unborn child.

Coverage for the child must continue for up to one year after birth unless otherwise prohibited by law or limited by the General Assembly through appropriations. Coverage for the mother is limited to pregnancy-related and postpartum care beginning on the day the pregnancy ends and extends through the last day of the month that includes the sixtieth day after the pregnancy ends unless otherwise prohibited by law or limited by the General Assembly through appropriations.

The bill specifies how the department may provide coverage for an unborn child enrolled in the program. The department must provide information about the program to maternity homes as defined in Section 135.600, pregnancy resource centers as defined in Section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. The department must consider allowing these agencies and programs to assist in enrolling unborn children in the program and in making determinations about presumptive eligibility and verification of the pregnancy.

Within 60 days after the effective date of these provisions, the department must submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the program.

At least annually, the Department of Social Services must prepare and submit a report to the Governor, the Speaker of the House of Representatives, and the President Pro Tem of the Senate analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement

agencies, correctional centers, health care providers, employers, other public and private entities and persons by enrolling unborn children in the program. The bill specifies the information that must be included in this analysis.

The program is not to be deemed an entitlement program, but instead is subject to a federal allotment or other federal appropriations and matching state appropriations.

The state is not obligated to continue the program if the allotment or payments from the federal government end or are not sufficient for the program to operate or if the General Assembly does not appropriate funds for the program.

These provisions must not be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state.

OPTOMETRIC SERVICES (Section 376.685)

The bill prohibits an agreement, for the provision of services, between a health carrier or other insurer that writes vision insurance and an optometrist from requiring an optometrist to provide additional services or materials at a limited or lower fee unless the services or materials are reimbursed as covered services under the contract. A provider is prohibited from charging more for services or materials that are not covered under a health benefit or vision plan than the usual and customary rate charged for those services or materials. The bill prohibits a contractual discount from resulting in a fee that is less than the health benefit or vision plan that would otherwise pay for covered services or materials if not for the application of an enrollee's contractual limitations of deductibles, co-payments, co-insurance, waiting periods, annual or lifetime maximums, alternative benefit payments, or frequency limitations. The reimbursement paid by the health or benefit plan for covered services or materials must be reasonable and cannot provide minimal reimbursement in order to claim a service or material is a covered service. A health carrier is prohibited from providing de minimis reimbursement or coverage in an attempt to avoid these provisions.

EXCEPTED BENEFIT PLANS (Section 376.998)

The bill prohibits any health insurance mandate that is applicable to health benefit plans written by a health carrier from applying to excepted benefit plans. For purposes of the exemption under this section, a "health insurance mandate" means a state requirement for a health carrier to offer or provide coverage for:

(1) A treatment by a particular type of health care provider;

(2) A certain treatment or service, including procedures, medical equipment, or drugs that are used in connection with a treatment or service; and

(3) Screening, diagnosis, or treatment of a particular disease or condition.

The bill requires that all excepted benefit plans issued on or after January 1, 2015, must include a disclaimer printed in no less than 12-point font on the front of the policy, certificate, application and enrollment form, and all advertising materials which states:

"NOTICE TO CONSUMER: THIS PLAN IS NOT CONSIDERED "MINIMUM ESSENTIAL COVERAGE" AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. THIS PLAN HAS LIMITS AND EXCLUSIONS AND MAY NOT COVER ALL HEALTH BENEFITS OR SERVICES."

If plan identification cards are issued to enrollees of excepted benefit plans, the cards must clearly and conspicuously state on the front of the card: "THIS IS NOT MINIMUM ESSENTIAL COVERAGE."

These provisions apply to all insurers that provide coverage to residents of this state that is issued or renewed on or after January 1, 2015.

HEALTH EXCHANGE NAVIGATOR LICENSING (Section 376.2004)

The bill requires that an applicant for a navigator license must take an exam administered by the Department of Insurance, Financial Institutions and Professional Registration or an independent testing service that the department has contracted and requires applicants for individual licenses to provide two sets of fingerprints for the purpose of doing Missouri and national criminal record reviews.

PROPONENTS: Supporters say that the bill helps to protect Missourians. The bill requires that navigators take an examination and submit fingerprints so the department can conduct a background check. Navigators handle very sensitive personal information and it is the duty of the state to protect Missourians from people who may want to use this information incorrectly.

Testifying for the bill were Representative Austin; Missouri Association of Insurance Agents; and Missouri Association of Insurance and Financial Advisors.

OPPONENTS: There was no opposition voiced to the committee.