

House _____ Amendment NO. _____

Offered By

1 AMEND House Committee Bill No. 10, Page 3, Section 374.191, Line 9, by inserting after all of
2 said line the following:

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

7 376.385. 1. Each entity offering individual and group health insurance policies providing
8 coverage on an expense-incurred basis, individual and group service or indemnity type contracts
9 issued by a health services corporation, individual and group service contracts issued by a health
10 maintenance organization, all self-insured group arrangements, to the extent not preempted by
11 federal law, and all managed health care delivery entities of any type or description, that are
12 delivered, issued for delivery, continued or renewed in this state on or after January 1, 1998, shall
13 offer coverage for all physician-prescribed medically appropriate and necessary equipment, supplies
14 and self-management training used in the management and treatment of diabetes. Coverage shall
15 include persons with gestational, type I or type II diabetes.

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

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

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

23 376.429. 1. All health benefit plans, as defined in section 376.1350, that are delivered,
24 issued for delivery, continued or renewed on or after August 28, 2006, and providing coverage to
25 any resident of this state shall provide coverage for routine patient care costs as defined in
26 subsection 7 of this section incurred as the result of phase II, III, or IV of a clinical trial that is
27 approved by an entity listed in subsection 4 of this section and is undertaken for the purposes of the
28 prevention, early detection, or treatment of cancer. Health benefit plans may limit coverage for the
29 routine patient care costs of patients in phase II of a clinical trial to those treating facilities within
30 the health benefit plans' provider network; except that, this provision shall not be construed as
31 relieving a health benefit plan of the sufficiency of network requirements under state statute.

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

Action Taken _____ Date _____

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

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

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

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

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

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

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

- 33 (1) "Cooperative group", a formal network of facilities that collaborate on research projects
 34 and have an established NIH-approved Peer Review Program operating within the group, including
 35 the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
- 36 (2) "Multiple project assurance contract", a contract between an institution and the federal
 37 Department of Health and Human Services (DHHS) that defines the relationship of the institution to
 38 the DHHS and sets out the responsibilities of the institution and the procedures that will be used by
 39 the institution to protect human subjects;
- 40 (3) "Routine patient care costs" shall include coverage for reasonable and medically
 41 necessary services needed to administer the drug or device under evaluation in the clinical trial.
 42 Routine patient care costs include all items and services that are otherwise generally available to a
 43 qualified individual that are provided in the clinical trial except:
 - 44 (a) The investigational item or service itself;
 - 45 (b) Items and services provided solely to satisfy data collection and analysis needs and that
 46 are not used in the direct clinical management of the patient; and
 - 47 (c) Items and services customarily provided by the research sponsors free of charge for any
 48 enrollee in the trial.

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

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

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

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

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

2. 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, hospitalization-surgical care policy, short-term major medical policy [~~of six months or less duration~~] having a duration of less than one year, or any other supplemental policy.

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

Further amend said bill, Page 4, Section 376.625, Line 10, by inserting after all of said line the following:

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

2. Insurers, corporations or groups providing coverage may approve for payment or reimbursement vendors and programs providing services or treatment required by this section. Any vendor or person offering services or treatment subject to the provisions of this section and seeking approval for payment or reimbursement shall submit to the department of mental health a detailed description of the services or treatment program to be offered. The department of mental health shall make copies of such descriptions available to insurers, corporations or groups providing coverage under the provisions of this section. Each insurer, corporation or group providing coverage shall notify the vendor or person offering service or treatment as to its acceptance or

1 rejection for payment or reimbursement; provided, however, payment or reimbursement shall be
 2 made for any service or treatment program certified by the department of mental health. Any notice
 3 of rejection shall contain a detailed statement of the reasons for rejection and the steps and
 4 procedures necessary for acceptance. Amended descriptions of services or treatment programs to be
 5 offered may be filed with the department of mental health. Any vendor or person rejected for
 6 approval of payment or reimbursement may modify their description and treatment program and
 7 submit copies of the amended description to the department of mental health and to the insurer,
 8 corporation or group which rejected the original description.

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

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

14 5. This section shall not apply to a supplemental insurance policy, including a life care
 15 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
 16 benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care
 17 policy, short-term major medical policy [~~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 of
 19 insurance, financial institutions and professional registration.

20 376.781. 1. All group health insurance policies providing coverage on an expense-incurred
 21 basis, all group service or indemnity contracts issued by a not-for-profit health service corporation,
 22 all self-insured group health benefit plans of any type or description, and all such health plans or
 23 policies that are individually underwritten or provide for such coverage for specific individuals and
 24 the members of their families as nongroup policies, which provide for hospital treatment, shall offer
 25 coverage for the necessary care and treatment of loss or impairment of speech or hearing subject to
 26 the same durational limits, dollar limits, deductibles and coinsurance factors as other covered
 27 services in such policies or contracts. All Missouri group contracts issued or renewed on or after
 28 December 31, 1984, shall be subject to this section. Notwithstanding any construction or
 29 relationship of interdependent contracts or plans affecting coverage and payment of reimbursement
 30 prerequisites under the policy or contract, coverage required by this section shall be included in the
 31 policy or contract and payment provided as for other coverage in the same policy or contract.

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

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

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

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

46 6. The department of insurance, financial institutions and professional registration may issue
 47 rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated
 48 under the authority of this section shall become effective unless it has been promulgated pursuant to

the provisions of section 536.024.

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

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

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

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

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

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

(5) The coverages set forth in this subsection:

(a) Shall be subject to the same coinsurance, co-payment and deductible factors as apply to physical illness;

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

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

2. In addition to the coverages set forth in subsection 1 of this section, every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies, benefits or coverages for recognized mental illness, excluding chemical dependency, meeting the following minimum standards:

(1) Coverage for outpatient treatment, including treatment through partial- or full-day program services, for mental health services for a recognized mental illness rendered by a licensed professional to the same extent as any other illness;

(2) Coverage for residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness;

(3) Coverage for inpatient hospital treatment for a recognized mental illness to the same extent as for any other illness, not to exceed ninety days per year;

(4) The coverages set forth in this subsection shall be subject to the same coinsurance, co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical illness; and

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities

certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

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

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

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

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

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

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

6. 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, hospitalization-surgical care policy, short-term major medical policy [~~of six months or less duration~~] 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.

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

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

(2) "Health benefit plan", shall have the same meaning as such term is defined in section 376.1350; however, for purposes of this section "health benefit plan" does not include 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 policy [~~of six months or less duration~~] having a duration of less than one year, or any other supplemental policy;

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

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

(5) "Pharmacy care", medications prescribed by a licensed physician for an eating disorder and includes any health-related services deemed medically necessary to determine the need or effectiveness of the medications, but only to the extent that such medications are included in the insured's health benefit plan;

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

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

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

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

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

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

5. Coverage of the treatment of eating disorders may be subject to other general exclusions and limitations of the contract or benefit plan not in conflict with the provisions of this section, such as coordination of benefits, and utilization review of health care services, which includes reviews of medical necessity and care management. Medical necessity determinations and care management for the treatment of eating disorders shall consider the overall medical and mental health needs of the individual with an eating disorder, shall not be based solely on weight, and shall take into consideration the most recent Practice Guideline for the Treatment of Patients with Eating Disorders adopted by the American Psychiatric Association in addition to current standards based upon the medical literature generally recognized as authoritative in the medical community."; and

Further amend said bill, Page 4, Section 376.1110, Line 19, by inserting after all of said line the

1 following:

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

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

8 (1) Orally administered anticancer medication that is used to kill or slow the growth of
9 cancerous cells charged at the same co-payment, deductible, or coinsurance amount as intravenously
10 administered or injected cancer medication that is provided, regardless of formulation or benefit
11 category determination by the health carrier administering the health 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 the
14 most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the
15 American Psychiatric Association. The actuarial analysis shall assume the following are included in
16 health benefit plan coverage:

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

20 (b) Access to medical treatment that provides coverage for integrated care and treatment as
21 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 on
25 legislative research shall submit a report of the actuarial findings prescribed by this section to the
26 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 only,
36 Medicare supplement policy, long-term care policy, short-term major medical policies [~~of six~~
37 ~~months' or less duration~~] having a duration of less than one year, or any other supplemental policy.

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

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

43 376.1199. 1. Each health carrier or health benefit plan that offers or issues health benefit
44 plans providing obstetrical/gynecological benefits and pharmaceutical coverage, which are
45 delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002, shall:

46 (1) Notwithstanding the provisions of subsection 4 of section 354.618, provide enrollees
47 with direct access to the services of a participating obstetrician, participating gynecologist or
48 participating obstetrician/gynecologist of her choice within the provider network for covered

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

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

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

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

27
 28 No such deductible, coinsurance or co-payment shall be greater than any drug on the health benefit
 29 plan's formulary. As used in this section, "contraceptive" shall include all prescription drugs and
 30 devices approved by the federal Food and Drug Administration for use as a contraceptive, but shall
 31 exclude all drugs and devices that are intended to induce an abortion, as defined in section 188.015,
 32 which shall be subject to section 376.805. Nothing in this subdivision shall be construed to exclude
 33 coverage for prescription contraceptive drugs or devices ordered by a health care provider with
 34 prescriptive authority for reasons other than contraceptive or abortion purposes.

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

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

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

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

1 (2) Upon request of an enrollee who is a member of a group health benefit plan and who
2 states that the use or provision of contraceptives is contrary to his or her moral, ethical or religious
3 beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that excludes
4 coverage for contraceptives. Any administrative costs to a group health benefit plan associated with
5 such exclusion of coverage not offset by the decreased costs of providing coverage shall be borne by
6 the group policyholder or group plan holder;

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

12 5. Except for a health carrier that is exempted from providing coverage for contraceptives
13 pursuant to this section, a health carrier shall allow enrollees in a health benefit plan that excludes
14 coverage for contraceptives pursuant to subsection 4 of this section to purchase a health benefit plan
15 that includes coverage for contraceptives.

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

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

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

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

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

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

30
31 For purposes of this subsection, if new premiums are charged for a contract, plan, or policy, it shall
32 be determined to be a new contract, plan, or policy.

33 7. Health carriers shall not disclose to the person or entity who purchased the health benefit
34 plan the names of enrollees who exclude coverage for contraceptives in the health benefit plan or
35 who purchase a health benefit plan that includes coverage for contraceptives. Health carriers and
36 the person or entity who purchased the health benefit plan shall not discriminate against an enrollee
37 because the enrollee excluded coverage for contraceptives in the health benefit plan or purchased a
38 health benefit plan that includes coverage for contraceptives.

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

376.1200. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all 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 January 1, 1996, shall offer coverage for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants. The offer of benefits under this section shall be in writing and must be accepted in writing by the individual or group policyholder or contract holder.

2. Such health care service shall not be subject to any greater deductible or co-payment than any other health care service provided by the policy, contract or plan, except that the policy, contract or plan may contain a provision imposing a lifetime benefit maximum of not less than one hundred thousand dollars, for dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for breast cancer treatment. 3. Benefits may be administered for such health care service through a managed care program of exclusive and/or preferred contractual arrangements with one or more providers rendering such health care service. These contractual arrangements may provide that the provider shall hold the patient harmless for the cost of rendering such health care service if it is subsequently found by the entity authorized to resolve disputes that:

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

(2) Such care was not medically appropriate; or

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

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

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

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

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

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

4. This section shall not apply to supplemental insurance policies, including life care contracts, accident-only policies, specified disease policies, hospital policies providing a fixed daily benefit only, Medicare supplement policies, long-term care policies, coverage issued as a supplement to liability insurance, short-term major medical policies ~~[of six months or less duration]~~

1 having a duration of less than one year, and other supplemental policies as determined by the
2 department of insurance, financial institutions and professional registration.

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

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

9 376.1218. 1. Any health carrier or health benefit plan that offers or issues health benefit
10 plans, other than Medicaid health benefit plans, which are delivered, issued for delivery, continued,
11 or renewed in this state on or after January 1, 2006, shall provide coverage for early intervention
12 services described in this section that are delivered by early intervention specialists who are health
13 care professionals licensed by the state of Missouri and acting within the scope of their professions
14 for children from birth to age three identified by the Part C early intervention system as eligible for
15 services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et
16 seq. Such coverage shall be limited to three thousand dollars for each covered child per policy per
17 calendar year, with a maximum of nine thousand dollars per child.

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

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

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

36 5. No payment made for specified early intervention services shall be applied by the health
37 carrier or health benefit plan against any maximum lifetime aggregate specified in the policy or
38 health benefit plan if the carrier opts to satisfy its obligations under this section under subdivision
39 (2) of subsection 7 of this section. A health benefit plan shall be billed at the applicable Medicaid
40 rate at the time the covered benefit is delivered, and the health benefit plan shall pay the Part C early
41 intervention system at such rate for benefits covered by this section. Services under the Part C early
42 intervention system shall be delivered as prescribed by the individualized family service plan and an
43 electronic claim filed in accordance with the carrier's or plan's standard format. Beginning January
44 1, 2007, such claims' payments shall be made in accordance with the provisions of sections 376.383
45 and 376.384.

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

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

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

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

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

30 10. Notwithstanding the provisions of section 23.253 to the contrary, the provisions of this
 31 section shall not sunset.

32 376.1219. 1. Each policy issued by an entity offering individual and group health insurance
 33 which provides coverage on an expense-incurred basis, individual and group health service or
 34 indemnity type contracts issued by a nonprofit corporation, individual and group service contracts
 35 issued by a health maintenance organization, all self-insured group health arrangements to the extent
 36 not preempted by federal law, and all health care plans provided by managed health care delivery
 37 entities of any type or description, that are delivered, issued for delivery, continued or renewed in
 38 this state on or after September 1, 1997, shall provide coverage for formula and low protein
 39 modified food products recommended by a physician for the treatment of a patient with
 40 phenylketonuria or any inherited disease of amino and organic acids who is covered under the
 41 policy, contract, or plan and who is less than six years of age.

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

46 3. The coverage required by this section may be subject to the same deductible for similar
 47 health care services provided by the policy, contract, or plan as well as a reasonable coinsurance or
 48 co-payment on the part of the insured, which shall not be greater than fifty percent of the cost of the

1 formula and food products, and may be subject to an annual benefit maximum of not less than five
 2 thousand dollars per covered child. Nothing in this section shall prohibit a carrier from using
 3 individual case management or from contracting with vendors of the formula and food products.

4 4. This section shall not apply to a supplemental insurance policy, including a life care
 5 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
 6 benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies
 7 having a duration of less than one year, or any other supplemental policy as determined by the
 8 director of the department of insurance, financial institutions and professional registration.

9 376.1220. 1. Each policy issued by an entity offering individual and group health insurance
 10 which provides coverage on an expense-incurred basis, individual or group health service, or
 11 indemnity contracts issued by a nonprofit corporation, individual and group service contracts issued
 12 by a health maintenance organization, all self-insured group health arrangements to the extent not
 13 preempted by federal law, and all health care plans provided by managed health care delivery
 14 entities of any type or description that are delivered, issued for delivery, continued or renewed in
 15 this state shall provide coverage for newborn hearing screening, necessary rescreening, audiological
 16 assessment and follow-up, and initial amplification.

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

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

26 4. Coverage for newborn hearing screening and any necessary rescreening and audiological
 27 assessment shall be provided to newborns eligible for medical assistance pursuant to section
 28 208.151, and the children's health program pursuant to sections 208.631 to 208.660, with payment
 29 for the newborn hearing screening required in section 191.925, and any necessary rescreening,
 30 audiological assessment and follow-up, and amplification as described in section 191.928.

31 376.1224. 1. For purposes of this section, the following terms shall mean:

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

36 (2) "Autism service provider":

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Psychiatric care;

(b) Psychological care;

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

(d) Therapeutic care;

(e) Pharmacy care.

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

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

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

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

(3) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, a health carrier shall have the right to review the treatment plan not more than once every six months unless the health carrier and the individual's treating physician or

1 psychologist agree that a more frequent review is necessary. Any such agreement regarding the
2 right to review a treatment plan more frequently shall only apply to a particular individual being
3 treated for an autism spectrum disorder and shall not apply to all individuals being treated for
4 autism spectrum disorders by a physician or psychologist. The cost of obtaining any review or
5 treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

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

16 6. The maximum benefit limitation for applied behavior analysis described in subsection 5
17 of this section shall be adjusted by the health carrier at least triennially for inflation to reflect the
18 aggregate increase in the general price level as measured by the Consumer Price Index for All
19 Urban Consumers for the United States, or its successor index, as defined and officially published
20 by the United States Department of Labor, or its successor agency. Beginning January 1, 2012, and
21 annually thereafter, the current value of the maximum benefit limitation for applied behavior
22 analysis coverage adjusted for inflation in accordance with this subsection shall be calculated by the
23 director of the department of insurance, financial institutions and professional registration. The
24 director shall furnish the calculated value to the secretary of state, who shall publish such value in
25 the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt
26 from the provisions of section 536.021.

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

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

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

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

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

45
46 Such payments or reimbursements under this subsection to an autism service provider or a board-
47 certified behavior analyst shall include payments or reimbursements for services provided by a line
48 therapist under the supervision of such provider or behavior analyst if such services provided by the

1 line therapist are included in the treatment plan and are deemed medically necessary.

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

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

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

11 (1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section
12 1002(32);

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

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

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

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

21 14. 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, short-term
24 major medical policy [~~of six months or less duration~~] having a duration of less than one year, or any
25 other supplemental policy.

26 15. Any health carrier or other entity subject to the provisions of this section shall not be
27 required to provide reimbursement for the applied behavior analysis delivered to a person insured
28 by such health carrier or other entity to the extent such health carrier or other entity is billed for
29 such services by any Part C early intervention program or any school district for applied behavior
30 analysis rendered to the person covered by such health carrier or other entity. This section shall not
31 be construed as affecting any obligation to provide services to an individual under an individualized
32 family service plan, an individualized education plan, or an individualized service plan. This
33 section shall not be construed as affecting any obligation to provide reimbursement pursuant to
34 section 376.1218.

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

37 17. The director of the department of insurance, financial institutions and professional
38 registration shall grant a small employer with a group health plan, as that term is defined in section
39 379.930, a waiver from the provisions of this section if the small employer demonstrates to the
40 director by actual claims experience over any consecutive twelve-month period that compliance
41 with this section has increased the cost of the health insurance policy by an amount of two and a
42 half percent or greater over the period of a calendar year in premium costs to the small employer.

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

45 19. (1) By February 1, 2012, and every February first thereafter, the department of
46 insurance, financial institutions and professional registration shall submit a report to the general
47 assembly regarding the implementation of the coverage required under this section. The report shall
48 include, but shall not be limited to, the following:

1 (a) The total number of insureds diagnosed with autism spectrum disorder;
 2 (b) The total cost of all claims paid out in the immediately preceding calendar year for
 3 coverage required by this section;
 4 (c) The cost of such coverage per insured per month; and
 5 (d) The average cost per insured for coverage of applied behavior analysis;
 6 (2) All health carriers and health benefit plans subject to the provisions of this section shall
 7 provide the department with the data requested by the department for inclusion in the annual report.
 8 376.1225. 1. All individual and group health insurance policies providing coverage on an
 9 expense-incurred basis, individual and group service or indemnity type contracts issued by a
 10 nonprofit corporation, individual and group service contracts issued by a health maintenance
 11 organization, all self-insured group arrangements to the extent not preempted by federal law and all
 12 managed health care delivery entities of any type or description, that are delivered, issued for
 13 delivery, continued or renewed on or after August 28, 1998, shall provide coverage for
 14 administration of general anesthesia and hospital charges for dental care provided to the following
 15 covered persons:

16 (1) A child under the age of five;
 17 (2) A person who is severely disabled; or
 18 (3) A person who has a medical or behavioral condition which requires hospitalization or
 19 general anesthesia when dental care is provided.

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

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

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

29 376.1230. 1. Every policy issued by a health carrier, as defined in section 376.1350, shall
 30 provide coverage for chiropractic care delivered by a licensed chiropractor acting within the scope
 31 of his or her practice as defined in chapter 331. The coverage shall include initial diagnosis and
 32 clinically appropriate and medically necessary services and supplies required to treat the diagnosed
 33 disorder, subject to the terms and conditions of the policy. The coverage may be limited to
 34 chiropractors within the health carrier's network, and nothing in this section shall be construed to
 35 require a health carrier to contract with a chiropractor not in the carrier's network nor shall a carrier
 36 be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval
 37 has been obtained from the carrier by the enrollee. An enrollee may access chiropractic care within
 38 the network for a total of twenty-six chiropractic physician office visits per policy period, but may
 39 be required to provide the health carrier with notice prior to any additional visit as a condition of
 40 coverage. A health carrier may require prior authorization or notification before any follow-up
 41 diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of
 42 twenty-six in any policy period. The certificate of coverage for any health benefit plan issued by a
 43 health carrier shall clearly state the availability of chiropractic coverage under the policy and any
 44 limitations, conditions, and exclusions.

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

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

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

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

10 376.1232. 1. Each health carrier or health benefit plan that offers or issues health benefit
11 plans which are delivered, issued for delivery, continued, or renewed in this state on or after January
12 1, 2010, shall offer coverage for prosthetic devices and services, including original and replacement
13 devices, as prescribed by a physician acting within the scope of his or her practice.

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

16 3. The amount of the benefit for prosthetic devices and services under this section shall be
17 no less than the annual and lifetime benefit maximums applicable to the basic health care services
18 required to be provided under the health benefit plan. If the health benefit plan does not include any
19 annual or lifetime maximums applicable to basic health care services, the amount of the benefit for
20 prosthetic devices and services shall not be subject to an annual or lifetime maximum benefit level.
21 Any co-payment, coinsurance, deductible, and maximum out-of-pocket amount applied to the
22 benefit for prosthetic devices and services shall be no more than the most common amounts applied
23 to the basic health care services required to be provided under the health benefit plan.

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

30 376.1235. 1. No health carrier or health benefit plan, as defined in section 376.1350, shall
31 impose a co-payment or coinsurance percentage charged to the insured for services rendered for
32 each date of service by a physical therapist licensed under chapter 334 or an occupational therapist
33 licensed under chapter 324, for services that require a prescription, that is greater than the co-
34 payment or coinsurance percentage charged to the insured for the services of a primary care
35 physician licensed under chapter 334 for an office visit.

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

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

48 4. This section shall not apply to short-term major medical policies having a duration of less

1 than one year.

2 376.1237. 1. Each health carrier or health benefit plan that offers or issues health benefit
3 plans which are delivered, issued for delivery, continued, or renewed in this state on or after January
4 1, 2014, and that provides coverage for prescription eye drops shall provide coverage for the
5 refilling of an eye drop prescription prior to the last day of the prescribed dosage period without
6 regard to a coverage restriction for early refill of prescription renewals as long as the prescribing
7 health care provider authorizes such early refill, and the health carrier or the health benefit plan is
8 notified.

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

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

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

19 5. The provisions of this section shall terminate on January 1, 2020.

20 376.1250. 1. All individual and group health insurance policies providing coverage on an
21 expense-incurred basis, individual and group service or indemnity type contracts issued by a
22 nonprofit corporation, individual and group service contracts issued by a health maintenance
23 organization, all self-insured group arrangements to the extent not preempted by federal law and all
24 managed health care delivery entities of any type or description, that are delivered, issued for
25 delivery, continued or renewed on or after August 28, 1999, and providing coverage to any resident
26 of this state shall provide benefits or coverage for:

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

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

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

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

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

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

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

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

46 376.1253. 1. Each physician attending any patient with a newly diagnosed cancer shall
47 inform the patient that the patient has the right to a referral for a second opinion by an appropriate
48 board-certified specialist prior to any treatment. If no specialist in that specific cancer diagnosis

1 area is in the provider network, a referral shall be made to a nonnetwork specialist in accordance
2 with this section.

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

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

17 376.1275. 1. Each health carrier or health benefit plan that offers or issues health benefit
18 plans which are delivered, issued for delivery, continued, or renewed in this state on or after January
19 1, 2003, shall include coverage for their members for the cost for human leukocyte antigen testing,
20 also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization
21 in bone marrow transplantation. The testing must be performed in a facility which is accredited by
22 the American Association of Blood Banks or its successors, and is licensed under the Clinical
23 Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the
24 American Association of Blood Banks or its successors, the College of American Pathologists, the
25 American Society for Histocompatibility and Immunogenetics (ASHI) or any other national
26 accrediting body with requirements that are substantially equivalent to or more stringent than those
27 of the College of American Pathologists. At the time of testing, the person being tested must
28 complete and sign an informed consent form which also authorizes the results of the test to be used
29 for participation in the National Marrow Donor Program. The health benefit plan may limit each
30 enrollee to one such testing per lifetime to be reimbursed at a cost of no greater than seventy-five
31 dollars by the health carrier or health benefit plan.

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

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

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

42 376.1400. 1. Every health insurance carrier offering policies of insurance in this state shall
43 use standardized information for the explanation of benefits given to the health care provider
44 whenever a claim is paid or denied. As used in this section, the term "health insurance carrier" shall
45 have the meaning given to "health carrier" in section 376.1350. Nothing in this section shall apply
46 to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, short-
47 term major medical policies [~~of six months' or less duration~~] having a duration of less than one year,
48 other limited benefit health insurance policies.

2. The standardized information shall contain the following:

- (1) The name of the insured;
- (2) The insured's identification number;
- (3) The date of service;
- (4) Amount of charge;
- (5) Explanation for any denial;
- (6) The amount paid;
- (7) The patient's full name;
- (8) The name and address of the insurer; and
- (9) The phone number to contact for questions on explanation of benefits.

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

376.1550. 1. Notwithstanding any other provision of law to the contrary, each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a mental health condition, as defined in this section, and shall comply with the following provisions:

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

(2) The coverages set forth in this subsection:

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

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

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

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

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

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

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

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

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social

1 or occupational role functioning or both;

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

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

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

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

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

13 3. This section shall not apply to a health plan or policy that is individually underwritten or
14 provides such coverage for specific individuals and members of their families pursuant to section
15 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836, a supplemental insurance
16 policy, including a life care contract, accident-only policy, specified disease policy, hospital policy
17 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
18 hospitalization-surgical care policy, short-term major medical policies ~~[of six months or less~~
19 ~~duration]~~ having a duration of less than one year, or any other supplemental policy as determined by
20 the director of the department of insurance, financial institutions and professional registration.

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

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

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

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

30 (3) Care that is custodial in nature;

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

32 (5) Treatments that are considered experimental.

33 6. The director shall grant a policyholder a waiver from the provisions of this section if the
34 policyholder demonstrates to the director by actual experience over any consecutive twenty-four-
35 month period that compliance with this section has increased the cost of the health insurance policy
36 by an amount that results in a two percent increase in premium costs to the policyholder. The
37 director shall promulgate rules establishing a procedure and appropriate standards for making such a
38 demonstration. Any rule or portion of a rule, as that term is defined in section 536.010, that is
39 created under the authority delegated in this section shall become effective only if it complies with
40 and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This
41 section and chapter 536 are nonseverable and if any of the powers vested with the general assembly
42 pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are
43 subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or
44 adopted after August 28, 2004, shall be invalid and void.

45 376.1900. 1. As used in this section, the following terms shall mean:

46 (1) "Electronic visit", or "e-visit", an online electronic medical evaluation and management
47 service completed using a secured web-based or similar electronic-based communications network
48 for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of

1 a patient with the health care provider, be completed using a federal Health Insurance Portability
2 and Accountability Act (HIPAA)-compliant online connection, and include a permanent record of
3 the electronic visit;

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

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

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

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

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

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

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

18 4. A health carrier shall not be required to reimburse a telehealth provider or a consulting
19 provider for site origination fees or costs for the provision of telehealth services; however, subject to
20 correct coding, a health carrier shall reimburse a health care provider for the diagnosis, consultation,
21 or treatment of an insured or enrollee when the health care service is delivered through telehealth on
22 the same basis that the health carrier covers the service when it is delivered in person.

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

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

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

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

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

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

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