

House _____ Amendment NO. _____

Offered By _____

1 AMEND House Bill No. 1383, Page 1, Section 9.166, Line 3, by inserting after said section and line
2 the following:

3
4 "376.1550. 1. Notwithstanding any other provision of law to the contrary, each health
5 carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued,
6 or renewed in this state on or after January 1, 2005, shall provide coverage for a mental health
7 condition, as defined in this section, and shall comply with the following provisions:

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

14 (2) The coverages set forth ~~[is]~~ in this subsection:

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

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

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

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

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

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

33 (4) ~~[Coverage for treatment for chemical dependency shall comply with sections 376.779,~~
34 ~~376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term~~
35 ~~"health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to 376.836,~~
36 ~~the term "health insurance policy" shall include group coverage]~~ A health benefit plan shall not

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impose a nonquantitative treatment limitation with respect to mental health condition benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health condition benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical or surgical benefits in the classification.

Nonquantitative treatment limitations include:

(a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(b) Formulary design for prescription drugs;

(c) For plans with multiple network tiers, such as preferred providers and participating providers, network tier design;

(d) Standards for provider admission to participate in a network, including reimbursement rates;

(e) Plan methods for determining usual, customary, and reasonable charges;

(f) Refusal to pay for higher cost therapies until it can be shown that a lower cost therapy is not effective;

(g) Exclusions based on failure to complete a course of treatment;

(h) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(i) In- and out-of-network geographic limitations;

(j) Standards for providing access to out-of-network providers;

(k) Limitations on inpatient services for situations when the participant is a threat to self or others;

(l) Exclusions for court-ordered and involuntary holds;

(m) Experimental treatment limitations;

(n) Service coding;

(o) Exclusions for services provided by clinical social workers; and

(p) Network adequacy.

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 or occupational role functioning or both]~~ "Classification of benefits", the classification to which all mental health condition benefits and medical or surgical benefits shall be assigned and include:

(a) Inpatient in-network;

(b) Inpatient out-of-network;

(c) Outpatient in-network;

(d) Outpatient out-of-network;

(e) Emergency care; and

(f) Prescription drugs;

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

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

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

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

(6) "Nonquantitative treatment limitation", any limitation on the scope or duration of

1 treatment that is not expressed numerically;

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

5 3. This section shall not apply to ~~[a health plan or policy that is individually underwritten or~~
6 ~~provides such coverage for specific individuals and members of their families pursuant to section~~
7 ~~376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836,]~~ a supplemental insurance
8 policy, including a life care contract, accident-only policy, specified disease policy, hospital policy
9 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
10 hospitalization-surgical care policy, short-term major medical policies of six months or less
11 duration, or any other supplemental policy as determined by the director of the department of
12 commerce and insurance.

13 4. Notwithstanding any other provision of law to the contrary, all health insurance policies
14 that cover state employees, including the Missouri consolidated health care plan, shall include
15 coverage for mental ~~[illness]~~ health conditions. Multiyear group policies need not comply until the
16 expiration of their current multiyear term unless the policyholder elects to comply before that time.

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

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

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

22 (3) Care that is custodial in nature;

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

24 (5) Treatments that are considered experimental.

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

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