SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILLS NOS. 807, 553, 574, 614, 747 & 860

90TH GENERAL ASSEMBLY

Reported from the Committee on Insurance and Housing, February 17, 2000, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

3574S.02C

AN ACT

To repeal section 148.400, RSMo 1994, and sections 317.001 and 376.1361, RSMo Supp. 1999, and to enact in lieu thereof ten new sections relating to insurance.

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

Section A. Section 148.400, RSMo 1994, and sections 317.001 and 376.1361, RSMo Supp. 1999, are repealed and ten new sections enacted in lieu thereof, to be known as sections 148.400, 317.001, 317.019, 335.018, 376.1190, 376.1361, 376.1364, 376.1405, 376.1406 and 376.1408, to read as follows:

148.400. All insurance companies or associations organized in or admitted to this state may deduct from premium taxes payable to this state, in addition to all other credits allowed by law, income taxes, franchise taxes, personal property taxes, valuation fees, registration fees and examination fees paid, including taxes and fees paid by the attorney in fact of a reciprocal or interinsurance exchange to the extent attributable to the principal business as such attorney in fact, **[**under**] pursuant to** any law of this state. **Any deduction for examination fees paid during a tax year which exceeds premium taxes payable for that year shall not be refunded, but may be carried forward to subsequent tax years until exhausted.**

317.001. As used in sections 317.001 to 317.021, the following words and terms mean:

(1) "Bout", one match involving either professional boxing, sparring, professional wrestling, professional kickboxing or professional full-contact karate;

(2) "Combative fighting", also known as "toughman fighting", "toughwoman fighting",

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

"badman fighting", "ultimate fighting", "U.F.C." and "extreme fighting", any boxing or wrestling match, contest or exhibition, between two or more contestants, with or without protective headgear, who use their hands, with or without gloves, or their feet, or both, and who compete for a financial prize or any item of pecuniary value, and which match, contest, tournament championship or exhibition is not recognized by and not sanctioned by any officially recognized state, regional or national boxing or athletic sanctioning authority, or any promoter duly licensed by the department of economic development;

(3) "Contest", a bout or a group of bouts involving licensed contestants competing in professional boxing, sparring, professional wrestling, professional kickboxing or professional full-contact karate;

(4) "Contestant", a person who competes in any activity covered by sections 317.001 to 317.021;

(5) "Department", the department of economic development;

(6) "Director", the director of the department of economic development;

(7) "Fund", the athletic fund established pursuant to sections 317.001 to 317.021;

(8) "Mandatory count of eight", a required count of eight that is given by a referee to a contestant who has been knocked down;

(9) "Noncompetitive boxing", boxing or sparring where a decision is not rendered;

(10) "Office", the department of economic development, division of professional registration, office of athletics;

(11) "Professional boxing", the sport of attack and defense which uses the fist and where contestants compete for valuable consideration;

(12) "**Professional boxing promoter", any person, association, partnership, corporation or organization that holds a license or permit to organize, promote and produce professional boxing contests;**

(13) "Professional full-contact karate", any form of full-contact martial arts including but not limited to full-contact kungfu, full-contact taw kwon-do, or any form of martial arts or self-defense conducted on a full-contact basis in a bout or contest where weapons are not used and where contestants compete for valuable consideration. Such contests take place in a rope-enclosed ring and are fought in timed rounds;

[(13)**] (14)** "Professional kickboxing", any form of boxing in which blows are delivered with any part of the arm below the shoulder, including the hand, and any part of the leg below the hip, including the foot, and where contestants compete for valuable consideration. Such contests take place in a rope-enclosed ring and are fought in timed rounds;

[(14)**] (15)** "Professional wrestling", any performance of wrestling skills and techniques by two or more professional wrestlers, to which any admission is charged. Participating wrestlers may not be required to use their best efforts in order to win, the winner may have been selected

before the performance commences and contestants compete for valuable consideration. Such contests take place in a rope-enclosed ring and are fought in timed rounds;

[(15)**] (16)** "Sparring", boxing for practice or as an exhibition;

[(16)**] (17)** "Standing mandatory eight count", the count of eight that is given at the discretion of a referee to a contestant who has been dazed by a blow and is unable to defend himself or herself. The standing mandatory eight count may be waived in a bout only with special permission of the office.

317.019. 1. The division of professional registration shall not issue any license or permit to a professional boxing promoter unless the promoter files proof of insurance not less than one hundred thousand dollars for each contestant participating in a professional boxing contest. This insurance shall cover:

(1) Hospital, medication, physician and other such expenses as would accrue in the treatment of an injury as a result of the boxing contest; and

(2) Payment to the estate of the contestant in the event of his or her death as a result of his or her participation in the boxing contest.

2. The insurance required pursuant to this section shall not apply to not for profit organizations sponsoring boxing contests.

335.018. 1. As used in section 376.1190, RSMo, "registered nurse first assistant" means any person practicing in this state as a registered nurse who is licensed pursuant to this chapter and who:

(1) Is certified by a nationally recognized professional organization for registered nurse first assistants; or

(2) Meets the criteria for registered nurse first assistants established by the Missouri state board of nursing.

2. The Missouri state board of nursing shall promulgate rules pursuant to chapter 536, RSMo, specifying which professional nursing organization certifications will be recognized for registered nurse first assistants and establishing the criteria a registered nurse must satisfy to use the title of registered nurse first assistant if the nurse if not certified by a nationally recognized professional nursing organization as a registered nurse first assistant.

376.1190. Any entity offering individual or group health insurance policies providing coverage on an expense-incurred basis, any health services corporation issuing individual or group service or indemnity type contracts, any health maintenance organization issuing individual or group service contracts, any entity providing medical coverage for injured workers pursuant to chapter 287, RSMo, all self-insured group arrangements to the extent not preempted by federal law, all managed health care delivery entities of any type or description and benefit payments made pursuant to section 208.152, RSMo, that are delivered, issued for delivery, continued or

renewed in this state on or after January 1, 2001, and that provide coverage for medical services, surgical services, diagnostic procedures, clinical laboratory services, durable medical equipment, radiology services, prescription drugs, physical therapy services or occupational therapy services shall also provide, within such coverage, for such services provided by a registered nurse first assistant as defined in section 335.018, RSMo, practicing as an independent contractor consistent with his or her scope of practice.

376.1361. 1. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request by either the director of the department of health or the director of the department of insurance.

2. Any medical director who administers the utilization review program or oversees the review decisions shall be a qualified health care professional licensed in the state of Missouri. A licensed clinical peer shall evaluate the clinical appropriateness of adverse determinations.

3. A health carrier shall issue utilization review decisions in a timely manner pursuant to the requirements of sections 376.1363, 376.1365 and 376.1367. A health carrier shall obtain all information required to make a utilization review decision, including pertinent clinical information. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

4. A health carrier's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

5. If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which shall include:

(1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(2) Evidence of formal approval of the utilization review organization program by the health carrier; and

(3) A process by which the health carrier evaluates the performance of the utilization review organization.

6. The health carrier shall coordinate the utilization review program with other medical management activities conducted by the carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for accessing member satisfaction and risk management.

7. A health carrier shall provide enrollees and participating providers with timely access

to its review staff by a toll-free number.

8. When conducting utilization review, the health carrier shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency and duration of services.

9. Compensation to persons providing utilization review services for a health carrier shall not contain direct or indirect incentives for such persons to make medically inappropriate review decisions. Compensation to any such persons may not be directly or indirectly based on the quantity or type of adverse determinations rendered.

10. A health carrier shall permit enrollees or a provider on behalf of an enrollee to appeal for the coverage of medically necessary pharmaceutical prescriptions and durable medical equipment as part of the health carriers' utilization review process.

11. (1) This subsection shall apply to:

(a) Any health benefit plan that is issued, amended, delivered or renewed on or after January 1, 1998, and provides coverage for drugs; or

(b) Any person making a determination regarding payment or reimbursement for a prescription drug pursuant to such plan.

(2) A health benefit plan that provides coverage for drugs shall provide coverage for any drug prescribed to treat an indication so long as the drug has been approved by the FDA for at least one indication, if the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature and deemed medically appropriate.

(3) This section shall not be construed to require coverage for a drug when the FDA has determined its use to be contraindicated for treatment of the current indication.

(4) A drug use that is covered pursuant to subsection 1 of this section shall not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use.

(5) Any drug or service furnished in a research trial, if the sponsor of the research trial furnishes such drug or service without charge to any participant in the research trial, shall not be subject to coverage pursuant to subsection 1 of this section.

(6) Nothing in this section shall require payment for nonformulary drugs, except that the state may exclude or otherwise restrict coverage of a covered outpatient drug from Medicaid programs as specified in the Social Security Act, Section 1927(d)(1)(B).

12. A carrier shall issue a confirmation number to an enrollee when the health carrier, acting through a participating provider or other authorized representative, authorizes the provision of health care services.

13. If an authorized representative of a health carrier authorizes the provision of health care services, the health carrier shall not subsequently retract its authorization after the health

care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless

(1) Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or

(2) The health benefit plan terminates before the health care services are provided; or

(3) The covered person's coverage under the health benefit plan terminates before the health care services are provided**; or**

(4) The health carrier's coverage is secondary to other valid insurance coverage applicable to the health care services pursuant to a coordination of benefits provision in the health benefit plan.

14. "Authorization", as used in subsections 12 and 13 of this section shall mean a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

376.1364. 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 nonprofit 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 provide coverage for surgical procedures must reply to an enrollee's surgeon or primary care physician within forty-eight hours, when an enrollee has been pre-approved for a surgical procedure, regarding such enrollee's eligibility for the surgical procedure. If the enrollee is determined to be eligible for the surgical procedure, then the entity is bound to its eligibility determination for thirty days following notification to the enrollee, the enrollee's surgeon, or the enrollee's primary care physician. Coverage for surgical procedures shall be subject to other terms and conditions as applicable to other benefits.

376.1405. 1. Every health insurance carrier offering policies of insurance in this state shall use the explanation of Medicare benefits Part B (EMOB) form for the explanation of benefits given to the health care provider whenever a claim is paid or denied. As used in this section, the term "health insurance carrier" shall have the meaning given to "health carrier" in section 376.1350. Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

2. All health insurance carriers shall use the explanation of Medicare benefits

Part B (EMOB) form after January 1, 2002.

376.1406. 1. Every health care provider and health carrier that conducts business in this state shall use a standardized form for referrals. The standardized referral form shall be used in lieu of any specific referral form developed by a health carrier for the referral process. As used in this section, the terms "health care provider" and "health carrier" shall have the meaning given to them in section 376.1350.

2. The referral form developed by the task force as established in section 376.1408 shall contain the following:

(1) The name of the insured;

(2) Place of employment;

(3) The name, address and phone number of the health carrier;

(4) The identification number and group number of the insured;

(5) The type of referral;

(6) The name, address and phone number of the health care provider referring the insured;

(7) The name, address, and phone number of the health care provider of whom the insured was referred to;

(8) The number of visits requested and authorized; and

(9) The health carrier's authorization number.

3. All health care providers and health carriers shall use the standardized referral form after January 1, 2002.

376.1408. 1. The department of insurance shall establish a task force to develop the standardized forms required by section 376.1406. The task force shall meet for soliciting information to develop the standardized forms. The task force shall consist of the following members:

(1) Three health care providers;

(2) Three representatives from the insurance industry; and

(3) Three members from the general public.

2. No member of the task force shall receive compensation for the performance of duties related to the task force but shall be reimbursed for reasonable and necessary expenses incurred in the performance of such duties.

3. The department of insurance shall have the task force established by January 1, 2001.

✓