SECOND REGULAR SESSION

SENATE BILL NO. 805

92ND GENERAL ASSEMBLY

INTRODUCED BY SENATOR LOUDON.

Pre-filed December 1, 2003, and ordered printed.

TERRY L. SPIELER, Secretary.

3101S.01I

AN ACT

To repeal section 376.995, RSMo, and to enact in lieu thereof seven new sections relating to mandated benefits for health insurance.

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

Section A. Section 376.995, RSMo, is repealed and seven new sections enacted in lieu thereof, to be known as sections 376.995, 376.1578, 376.1581, 376.1584, 376.1587, 376.1590, and 376.1593, to read as follows:

376.995. 1. This section shall be known as the "Limited Mandate Health Insurance Act".

2. Limited mandate health insurance policies and contracts shall mean those policies and contracts of health insurance as defined in section 376.960 and which cover individuals and their families (but not including any Medicare supplement policy or contract) and groups sponsored by an employer who employs fifty or fewer persons.

3. **Notwithstanding any other provision of law to the contrary,** no law requiring the coverage of a particular health care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, shall apply to limited mandate health insurance policies and contracts**[**, except the following provisions:

(1) Subsection 1 of section 354.095, RSMo, to the extent that it regulates maternity benefits;

(2) Section 375.995, RSMo;

(3) Section 376.406;

(4) Section 376.428;

(5) Section 376.782;

(6) Section 376.816;

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

(7) Section 376.1210;

(8) Section 376.1215; and

(9) Section 376.1219**]**. **The requirements contained in this section for benefits provided under limited mandate health insurance policies and contracts shall be the exclusive requirements for such policies and contracts.**

4. In order for an insurer as defined in section 376.960 to be eligible to market, sell or issue limited mandate health insurance, the insurer shall:

(1) **[**Restrict its marketing and sales efforts to only those persons or groups as defined in subsection 2 of this section which currently do not have health insurance coverage or to those persons or employers which certify in writing to the insurer that they will terminate the coverage they currently have at the time they would otherwise renew coverage because of cost;

(2)**]** Fully and clearly disclose to the person or group to whom the limited mandate health insurance policy or contract is to be issued that the reason coverage for this product is less expensive than other coverage is because the policy or contract does not contain coverages or health professional payment mechanisms that are required by subsection 3 of this section;

[(3)**]** **(2)** Clearly disclose in all sales, promotional and advertising material related thereto that the product is a limited mandate health insurance policy or contract.

5. The provisions of section 376.441 shall not apply to any group which replaces its current coverage with a limited mandate health insurance policy or contract if the benefit to be extended is one for services which are not covered by the replacing policy or contract.

6. Notwithstanding any other provision of this section to the contrary, the provisions of paragraph (b) of subdivision (11) of section 375.936, RSMo, shall apply to limited mandate health insurance policies with respect to physician services covered under such policies, which can be provided by persons licensed pursuant to section 332.181, RSMo.

376.1578. As used in sections 376.1578 to 376.1593, unless otherwise specifically provided, the following terms shall mean:

(1) "Appropriate committees of the general assembly" or "committees", standing committees of the Missouri state senate and house of representatives that have jurisdiction over issues that regulate health carriers, health care facilities, health care providers, or health care services;

(2) "Health carrier" or "carrier" shall have the same meaning as ascribed in section 376.1350;

(3) "Mandated health benefit", "mandated benefit", or "benefit", coverage or offering required by law to be provided by a health carrier to:

(a) Cover a specific health care service or services;

(b) Cover treatment of a specific condition or conditions; or

(c) Contract, pay, or reimburse specific categories of health care providers for specific services; a mandated option is not a mandated health benefit;

(4) "Mandated benefit review commission", the commission established pursuant to section 376.1581.

376.1581. 1. There is hereby established a commission to be known as the "Mandated Health Benefit Review Commission" within the department of insurance. The commission shall consist of the following members:

(1) The director of the department of insurance who shall serve in a nonvoting advisory capacity;

(2) The director of the department of health and senior services who shall serve in a nonvoting advisory capacity;

(3) Two members of the Missouri house of representatives, one from each major political party represented in the house of representatives, appointed by the speaker of the house who shall serve in a nonvoting advisory capacity;

(4) Two members of the senate, one from each major political party represented in the senate, appointed by the president pro tem of the senate who shall serve in a nonvoting advisory capacity;

(5) One member representing the interests of employers having more than one hundred employees, appointed by the governor with the advice and consent of the senate;

(6) One member representing the interests of employers having less than one hundred employees, appointed by the governor with the advice and consent of the senate;

(7) Two individual purchasers of health insurance policies, appointed by the governor with the advice and consent of the senate; and

(8) Two employees that pay a percentage of their health insurance sponsored by their employers, appointed by the governor with the advice and consent of the senate.

2. Members appointed by the governor shall serve for four-year terms and until their successors are appointed; provided, however, that the terms of half of the six original appointees shall be for two years. Other members, except legislative members, shall serve for as long as they hold the position which made them eligible for appointment. Legislative members shall serve during their current term of office but may be reappointed.

3. Members of the commission shall not be compensated for their services, but may be reimbursed for actual and necessary expenses incurred in the performance of their duties. The office of administration and the departments of health and insurance shall provide such support as the commission requires to aid

it in the performance of its duties. The commission may consult with experts from the health research, biostatistics, actuarial science, and other areas the commission deems appropriate.

4. The members appointed by the governor shall be residents of Missouri. Any vacancy on the commission shall be filled in the same manner as the original appointment.

5. The commission shall be established by October 1, 2004.

376.1584. 1. After the mandated health benefit review commission has been established pursuant to section 376.1581, the commission shall review all existing state health care mandates and issue a report to the president pro tem of the senate, the speaker of the house of representatives, and the respective committees in both houses which handle health and insurance issues. The commission shall review the projected costs of all existing state and federal mandated benefits. The report shall state the costs of all current state and federal mandated benefits and recommend to the general assembly which mandated benefits should be repealed from state law.

2. The commission shall submit the list of the proposed deletions of state mandated benefits to the general assembly no later than the tenth legislative day of the session beginning in January, 2006. Upon submission, the general assembly may introduce legislation implementing the recommendations of the mandated benefit review commission.

376.1587. If a legislative measure contains a mandated health benefit, the appropriate committee of the general assembly having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among the members of the committee. If there is support for the proposed mandate among a majority of the members of the committee, the committee may refer the proposal to the mandated health benefit review commission for review and evaluation pursuant to sections 376.1590 and 376.1593. Upon completion of a review and evaluation, the committee shall review the findings of the mandated health benefit review commission. No mandated health benefit shall be enacted into law prior to January 1, 2006, and after such date, no proposed mandate shall be enacted into law unless review and evaluation pursuant to sections 376.1590 and 376.1593 has been completed.

376.1590. Every proposed legislative measure that mandates a health insurance coverage, whether by requiring payment for certain providers or by requiring an offering of a health insurance coverage by an insurer or health carrier as a component of individual or group health insurance policies, shall be accompanied by a report prepared by the mandated health benefit review

commission that assesses both the social and financial effects of the coverage in the manner provided in section 376.1593, including the efficacy of the treatment or service proposed.

376.1593. Upon referral of a mandated health benefit proposal from the appropriate committee of the general assembly having jurisdiction over the proposal, the mandated health benefit review commission shall conduct a review and evaluation of the mandated health benefit proposal and shall report to the committee in a timely manner. The report shall include, at the minimum and to the extent that information is available, the following:

(1) The social impact of mandating the benefit, including:

(a) The extent to which the treatment or service is utilized by a significant portion of the population;

(b) The extent to which the treatment or service is available to the population;

(c) The extent to which insurance coverage for this treatment or service is already available;

(d) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(e) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(f) The level of public demand and the level of demand from providers for the treatment or service;

(g) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(h) The level of interest in and the extent to which collective bargaining organizations are negotiating privately for inclusion of this coverage in group contracts;

(i) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(j) The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(k) The alternatives to meeting the identified need;

(l) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(m) The impact of any social stigma attached to the benefit upon the market;

(n) The impact of this benefit on the availability of other benefits currently being offered;

(o) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans; and

(p) The impact of making the benefit applicable to the state employee health insurance program established pursuant to chapter 103, RSMo;

(2) The financial impact of mandating the benefit, including:

(a) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next five years;

(b) The extent to which the proposed coverage may increase the appropriate or inappropriate use of the treatment or service over the next five years;

(c) The extent to which the mandated treatment or service may serve as an alternative for more expensive or less expensive treatment or service;

(d) The methods that will be instituted to manage the utilization and costs of the proposed mandate;

(e) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years;

(f) The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(g) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(h) The impact of this coverage on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness;

(i) The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers; and

(j) The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this state;

(3) The medical efficacy of mandating the benefit, including:

(a) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research

demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

(b) If the legislation seeks to mandate coverage of an additional class of practitioners:

a. The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

b. The methods of the appropriate professional organization that assure clinical proficiency; and

(4) The effects of balancing the social, economic, and medical efficacy considerations, including:

(a) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;

(b) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and

(c) The cumulative impact of mandating this benefit in combination with existing mandates on the costs and availability of coverage.

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