

FIRST REGULAR SESSION
[P E R F E C T E D]
SENATE COMMITTEE SUBSTITUTE FOR
SENATE BILL NO. 122
96TH GENERAL ASSEMBLY

Reported from the Committee on Health, Mental Health, Seniors and Families, March 31, 2011, with recommendation that the Senate Committee Substitute do pass.

Senate Committee Substitute for Senate Bill No. 122, adopted April 6, 2011.

Taken up for Perfection April 6, 2011. Bill declared Perfected and Ordered Printed.

TERRY L. SPIELER, Secretary.

0757S.02P

AN ACT

To repeal section 354.535, RSMo, and to enact in lieu thereof three new sections relating to health insurance.

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

Section A. Section 354.535, RSMo, is repealed and three new sections
2 enacted in lieu thereof, to be known as sections 354.535, 376.387, and 376.475,
3 to read as follows:

354.535. 1. If a pharmacy, operated by or contracted with by a health
2 maintenance organization, is closed or is unable to provide health care services
3 to an enrollee in an emergency, a pharmacist may take an assignment of such
4 enrollee's right to reimbursement, if the policy or contract provides for such
5 reimbursement, for those goods or services provided to an enrollee of a health
6 maintenance organization. No health maintenance organization shall refuse to
7 pay the pharmacist any payment due the enrollee under the terms of the policy
8 or contract.

9 2. No health maintenance organization, conducting business in the state
10 of Missouri, shall contract with a pharmacy, pharmacy distributor or wholesale
11 drug distributor, nonresident or otherwise, unless such pharmacy or distributor
12 has been granted a permit or license from the Missouri board of pharmacy to
13 operate in this state.

14 3. Every health maintenance organization shall apply the same
15 coinsurance, co-payment and deductible factors to all drug prescriptions filled by
16 a pharmacy provider who participates in the health maintenance organization's
17 network if the provider meets the contract's explicit product cost determination.

18 If any such contract is rejected by any pharmacy provider, the health
19 maintenance organization may offer other contracts necessary to comply with any
20 network adequacy provisions of this act. However, nothing in this section shall
21 be construed to prohibit the health maintenance organization from applying
22 different coinsurance, co-payment and deductible factors between generic and
23 brand name drugs.

24 **4. If the co-payment applied by a health maintenance**
25 **organization exceeds the usual and customary retail price of the**
26 **prescription drug, enrollees shall only be required to pay the usual and**
27 **customary retail price of the prescription drug, and no further charge**
28 **to the enrollee or plan sponsor shall be incurred on such prescription.**

29 **5.** Health maintenance organizations shall not set a limit on the quantity
30 of drugs which an enrollee may obtain at any one time with a prescription, unless
31 such limit is applied uniformly to all pharmacy providers in the health
32 maintenance organization's network.

33 **[5.] 6.** Health maintenance organizations shall not insist or mandate any
34 physician or other licensed health care practitioner to change an enrollee's
35 maintenance drug unless the provider and enrollee agree to such change. For the
36 purposes of this provision, a maintenance drug shall mean a drug prescribed by
37 a practitioner who is licensed to prescribe drugs, used to treat a medical condition
38 for a period greater than thirty days. Violations of this provision shall be subject
39 to the penalties provided in section 354.444. Notwithstanding other provisions
40 of law to the contrary, health maintenance organizations that change an
41 enrollee's maintenance drug without the consent of the provider and enrollee
42 shall be liable for any damages resulting from such change. Nothing in this
43 subsection, however, shall apply to the dispensing of generically equivalent
44 products for prescribed brand name maintenance drugs as set forth in section
45 338.056.

376.387. If the co-payment for prescription drugs applied by a
2 **health insurer or health carrier, as defined in section 376.1350, exceeds**
3 **the usual and customary retail price of the prescription drug, enrollees**
4 **shall only be required to pay the usual and customary retail price of**
5 **the prescription drug, and no further charge to the enrollee or plan**
6 **sponsor shall be incurred on such prescription.**

376.475. 1. Every health carrier, as defined in section 376.1350,
2 **shall, by July 1, 2012, utilize a web-based estimating system or other**

3 mechanism, by which covered individuals, or their parents or
4 guardians, shall be able to enter, provide, or select from menus, the
5 procedures, tests, or services the individual is considering having, and
6 based upon the individual's benefit plan and the health carrier's
7 internal data, receive estimates of the total cost and total out-of-pocket
8 cost of the procedures, tests, or services specific to all available
9 contracted providers or facilities for which such estimates are
10 requested. The estimates shall take into account any known unmet
11 deductible obligation and shall be based upon assumptions of typical
12 utilization and an assumption that, in the provision of the procedures,
13 tests, or services, no complications or unexpected events would occur
14 necessitating other expenses. The estimates shall include related
15 estimates of typically needed and expected ancillary costs such as those
16 for radiology, pathology, or anesthesiology services, and shall indicate
17 when no contracted providers of such services are available under the
18 individual's benefit plan at a selected health care facility or
19 provider. Any estimate given shall not be a guarantee of coverage and
20 the health carrier shall not be held liable for differences between the
21 estimated costs and the ultimate charges assessed to the
22 individual. Nothing in this subsection shall be construed as violating
23 any provider contract provisions with a health carrier that prohibits
24 disclosure of a provider's fee schedule to third parties.

25 2. Any health carrier that has not made a good faith effort to
26 comply with the provisions of this section shall be subject to the
27 provisions of section 374.280.

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