FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 103

100TH GENERAL ASSEMBLY

0504H.03C DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal sections 190.205, 191.671, 376.385, 376.429, 376.446, 376.452, 376.454, 376.690, 376.779, 376.781, 376.782, 376.811, 376.845, 376.1199, 376.1200, 376.1209, 376.1210, 376.1215, 376.1218, 376.1219, 376.1220, 376.1224, 376.1225, 376.1230, 376.1232, 376.1235, 376.1237, 376.1250, 376.1253, 376.1257, 376.1275, 376.1290, 376.1400, 376.1550, and 376.1900, RSMo, and to enact in lieu thereof thirty-seven new sections relating to health care services.

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

Section A. Sections 190.205, 191.671, 376.385, 376.429, 376.446, 376.452, 376.454, 376.690, 376.779, 376.781, 376.782, 376.811, 376.845, 376.1199, 376.1200, 376.1209, 376.1210, 376.1215, 376.1218, 376.1219, 376.1220, 376.1224, 376.1225, 376.1230, 376.1232, 376.1235, 376.1237, 376.1250, 376.1253, 376.1257, 376.1275, 376.1290, 376.1400, 376.1550, and 376.1900, RSMo, are repealed and thirty-seven new sections enacted in lieu thereof, to be known as sections 190.205, 191.671, 376.008, 376.385, 376.429, 376.446, 376.452, 376.454, 376.690, 376.779, 376.781, 376.782, 376.811, 376.845, 376.1199, 376.1200, 376.1209, 376.1210, 376.1215, 376.1218, 376.1219, 376.1220, 376.1224, 376.1225, 376.1230, 376.1232, 376.1235, 376.1237, 376.1250, 376.1253, 376.1257, 376.1275, 376.1290, 376.1345, 376.1400, 376.1550, and 376.1900, to read as follows:

190.205. 1. Health carriers and managed care plans shall pay benefits directly to **ground and not-for-profit, hospital-based air** ambulance services or emergency medical response agencies.

2. Health carriers and managed care plans shall not prohibit or discourage the use of the 911 system when emergency services are needed as defined in section 190.100.

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

3. If a request for emergency services is made to an ambulance service which is not the 911 provider or the recognized emergency provider in areas not covered by 911 ambulance services, then the 911 provider or the recognized emergency provider shall be notified immediately by the ambulance service receiving the request.

191.671. 1. No other section of this act shall apply to any insurer, health services corporation, or health maintenance organization licensed by the department of insurance, financial institutions and professional registration which conducts HIV testing only for the purposes of assessing a person's fitness for insurance coverage offered by such insurer, health services corporation, or health maintenance corporation, except that nothing in this section shall be construed to exempt any insurer, health services corporation or health maintenance organization in their capacity as employers from the provisions of section 191.665 relating to employment practices.

2. Upon renewal of any individual or group insurance policy, subscriber contractor health maintenance organization contract covering medical expenses, no insurer, health services corporation or health maintenance organization shall deny or alter coverage to any previously covered individual who has been diagnosed as having HIV infection or any HIV-related condition during the previous policy or contract period only because of such diagnosis, nor shall any such insurer, health services corporation or health maintenance organization exclude coverage for treatment of such infection or condition with respect to any such individual. **The provisions of this subsection shall not apply to short-term major medical policies having a duration of less than one year.**

3. The director of the department of insurance, financial institutions and professional registration shall establish by regulation standards for the use of HIV testing by insurers, health services corporations and health maintenance organizations.

4. A laboratory certified by the U.S. Department of Health and Human Services under the Clinical Laboratory Improvement Act of 1967, permitting testing of specimens obtained in interstate commerce, and which subjects itself to ongoing proficiency testing by the College of American Pathologists, the American Association of Bio Analysts, or an equivalent program approved by the Centers for Disease Control shall be authorized to perform or conduct HIV testing for an insurer, health services corporation or health maintenance organization pursuant to this section.

5. The result or results of HIV testing of an applicant for insurance coverage shall not be disclosed by an insurer, health services corporation or health maintenance organization, except as specifically authorized by such applicant in writing. Such result or results shall, however, be disclosed to a physician designated by the subject of the test. If there is no physician designated, the insurer, health services corporation, or health maintenance organization shall

disclose the identity of individuals residing in Missouri having a confirmed positive HIV test result to the department of health and senior services. Provided, further, that no such insurer, health services corporation or health maintenance organization shall be liable for violating any duty or right of confidentiality established by law for disclosing such identity of individuals having a confirmed positive HIV test result to the department of health and senior services. Such disclosure shall be in a manner that ensures confidentiality. Disclosure of test results in violation of this section shall constitute a violation of sections 375.930 to 375.948 regulating trade practices in the business of insurance. Nothing in this subsection shall be construed to foreclose any remedies existing on June 1, 1988.

376.008. 1. All short-term major medical policies delivered or issued for delivery in this state shall include on any application for coverage and on the fact page of all policies a conspicuous and clearly captioned paragraph stating:

This policy may not cover preexisting conditions, including conditions you may currently have and are unaware of but are not diagnosed until the policy's term. This policy may not cover certain essential health benefits, including prescription drugs, preventative care, and emergency services. Before you realize benefits under this policy, you may be responsible for a deductible and/or coinsurance. Be sure to discuss these items with your insurance broker before purchasing a short-term medical policy.

2. No short-term major medical policy shall be delivered or issued for delivery in this state until the prospective insured has confirmed receipt of a benefit summary statement. As used in this section, "benefit summary statement" shall mean a no more than two-page plain language explanation of the following:

(1) Coverage limits, if any, expressed in dollars for:

(a) Each occurrence;

(b) Each covered benefit including, but not limited to, any benefit that is or was a covered benefit for any duration or dollar amount during the contract period and anything included under subdivision (2) of this subsection; and

(c) Each contract period;

(2) Co-payments and deductibles for each covered benefit including, but not limited to:

(a) Inpatient hospital care;

(b) Outpatient hospital care;

(c) Nonhospital inpatient care;

(d) Nonhospital outpatient care;

(e) Prescription drugs; and

(f) Emergency services; and

(3) Any co-payment or deductible for an illness or affliction which differs from the co-payment or deductible required to be described under subdivision (2) of this subsection.

376.385. 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, 1998, shall offer coverage for all physician-prescribed medically appropriate and necessary equipment, supplies and self-management training used in the management and treatment of diabetes. Coverage shall include persons with gestational, type I or type II diabetes.

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

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

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

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

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

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

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

(1) One of the National Institutes of Health (NIH);

(2) An NIH cooperative group or center as defined in subsection 7 of this section;

(3) The FDA in the form of an investigational new drug application;

(4) The federal Departments of Veterans' Affairs or Defense;

(5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or

(6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

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

(1) Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and

(2) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

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

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

(1) "Cooperative group", a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the

group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

(2) "Multiple project assurance contract", a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;

(3) "Routine patient care costs" shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigational item or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(c) Items and services customarily provided by the research sponsors free of charge for any 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~~**] co-payments**, 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. Health carriers shall permit individuals to learn the amount of cost-sharing, including deductibles, co-payments, and coinsurance, under an individual's short-term major medical policy, having a duration of less than one year, 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.

[~~2.~~**]** 3. 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~~**]**, or any other supplemental policy.

[~~3.~~**] 4.** The provisions of subsections 1 and 2 shall become effective on January 1, 2014.

376.452. 1. Except as provided in this section, if a health insurance issuer offers health insurance coverage in the large group market in connection with a group health plan, the health insurance issuer shall renew or continue the coverage in force at the option of the plan sponsor. **The provisions of this subsection shall not apply to short-term major medical policies having a duration of less than one year.**

2. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the large group market if:

(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or if the health insurance issuer has not received timely premium payments;

(2) The plan sponsor has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage;

(3) The plan sponsor has failed to comply with the health insurance issuer's minimum participation requirements;

(4) The plan sponsor has failed to comply with the health insurance issuer's employer contribution requirements;

(5) The health insurance issuer is ceasing to offer coverage in the large group market in accordance with subsection 3 of this section;

(6) In the case of a health insurance issuer that offers health insurance coverage in the large group market through a network plan, there is no longer any enrollee under the group health plan who lives, resides, or works in the service area of the health insurance issuer or in the area for which the issuer is authorized to do business;

(7) In the case of health insurance coverage that is made available in the large group market only through one or more bona fide associations, the membership of an employer in the bona fide association ceases, but only if coverage is terminated under this subdivision uniformly without regard to any health status-related factor of any covered individual.

3. A health insurance issuer shall not discontinue offering a particular type of group health insurance coverage offered in the large group market unless:

(1) The issuer provides notice to each plan sponsor, participant and beneficiary provided coverage of this type in the large group market of the discontinuation at least ninety days prior to the date of the discontinuation of the coverage;

(2) The issuer offers to each plan sponsor being provided coverage of this type in the large group market the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in the large group market; and

(3) The issuer acts uniformly without regard to the claims experience of those plan sponsors or any health status-related factor of any participant or beneficiary covered or new participant or beneficiary who may become eligible for such coverage.

4. (1) A health insurance issuer shall not discontinue offering all health insurance coverage in the large group market unless:

(a) The issuer provides notice of discontinuation to the director and to each plan sponsor, participant and beneficiary covered at least one hundred eighty days prior to the date of the discontinuation of coverage; and

(b) All health insurance issued or delivered for issuance in Missouri in the large group market is discontinued and coverage under such health insurance is not renewed.

(2) In the case of a discontinuation under this subsection, the health insurance issuer shall not provide for the issuance of any health insurance coverage in the large group market for a period of five years beginning on the date of the discontinuation of the last health insurance coverage not renewed.

5. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan in the large group market. For purposes of this subsection, renewal shall be deemed to occur not more often than annually on the anniversary of the effective date of the group health plan's health insurance coverage unless a longer term is specified in the policy or contract.

6. In the case of health insurance coverage that is made available by a health insurance issuer only through one or more bona fide associations, a reference to plan sponsor in this section is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

376.454. 1. Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual. **The provisions of this subsection shall not apply to short-term major medical policies having a duration of less than one year.**

2. A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) The issuer is ceasing to offer coverage in the individual market in accordance with subsection 4 of this section;

(4) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area or in an area for which the issuer is authorized to do business but only if such coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals;

(5) In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association on the basis of which the coverage is provided ceases, but only if such coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

3. In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if:

(1) The issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage;

(2) The issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(3) In exercising the option to discontinue coverage of this type and in offering the option of coverage under subdivision (2) of this subsection, the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

4. (1) In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in the state, health insurance coverage may be discontinued by the issuer only if:

(a) The issuer provides notice to the director and to each individual of such discontinuation at least one hundred eighty days prior to the date of the expiration of such coverage; and

(b) All health insurance issued or delivered for issuance in the state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.

(2) In the case of a discontinuation under subdivision (1) of this subsection, the issuer shall not provide for the issuance of any health insurance coverage in the individual market for a five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

5. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with applicable law and effective on a uniform basis among all individuals with that policy form. For purposes of this subsection, renewal shall be deemed to occur not more often than annually on the anniversary of the effective date of the individual's health insurance coverage or as specified in the policy or contract.

6. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an individual is deemed to include a reference to such an association of which the individual is a member.

7. An insurer shall provide a certification of creditable coverage as required by Public Law 104-191 and regulations pursuant thereto.

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

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged.

2. (1) Health care professionals **[**~~may~~**] shall** send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within one hundred eighty days of the delivery of the unanticipated out-of-network care on a U.S. Centers of Medicare and

Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

(2) Within forty-five processing days, as defined in section 376.383, of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's services. If the health care professional participates in one or more of the carrier's commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.

(3) If the health care professional declines the health carrier's initial offer of reimbursement, the health carrier and health care professional shall have sixty days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care.

(4) If the health carrier and health care professional do not agree to a reimbursement amount by the end of the sixty-day negotiation period, the dispute shall be resolved through an arbitration process as specified in subsection 4 of this section.

(5) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within one hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.

(6) No health care professional who sends a claim to a health carrier under subsection 2 of this section shall send a bill to the patient for any difference between the reimbursement rate as determined under this subsection and the health care professional's billed charge.

3. (1) When unanticipated out-of-network care is provided, the health care professional who sends a claim to a health carrier under subsection 2 of this section may bill a patient for no more than the cost-sharing requirements described under this section.

(2) Cost-sharing requirements shall be based on the reimbursement amount as determined under subsection 2 of this section.

(3) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within forty-five processing days of receiving a claim from the health care professional for services provided.

(4) The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care.

4. The director shall ensure access to an external arbitration process when a health care professional and health carrier cannot agree to a reimbursement under subdivision (3) of subsection 2 of this section. In order to ensure access, when notified of a parties' intent to arbitrate, the director shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between and will be directly billed to the health care professional and health carrier. These costs will include, but are not limited to, reasonable time necessary for the arbitrator to review materials in preparation for the arbitration, travel expenses and reasonable time following the arbitration for drafting of the final decision.

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of section 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare-allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

7. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. **[**~~This section shall take effect on January 1, 2019.~~

~~10.~~**]** The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to procedural requirements for arbitration. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

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 rejection for payment or reimbursement; provided, however, payment or reimbursement shall be made for any service or treatment program certified by the department of mental health. Any notice of rejection shall contain a detailed statement of the reasons for rejection and the steps and procedures necessary for acceptance. Amended descriptions of

services or treatment programs to be offered may be filed with the department of mental health. Any vendor or person rejected for approval of payment or reimbursement may modify their description and treatment program and submit copies of the amended description to the department of mental health and to the insurer, corporation or group which rejected the original description.

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

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

5. 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.

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

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

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

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

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

6. The department of insurance, financial institutions and professional registration may issue rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated 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.

376.782. 1. As used in this section, the term "low-dose mammography screening" means the X-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the X-ray tube, filter, compression device, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other physician for reading, interpreting or diagnosing based on such X-ray. As used in this section, the term "low-dose mammography screening" shall also include digital mammography and breast tomosynthesis. As used in this section, the term "breast tomosynthesis" shall mean a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

2. 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 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 are delivered, issued for delivery, continued or renewed on or after August 28, 1991, and providing coverage to any resident of this state shall provide benefits or coverage for low-dose mammography screening for any nonsymptomatic woman covered under such policy or contract which meets the minimum requirements of this section. Such benefits or coverage shall include at least the following:

(1) A baseline mammogram for women age thirty-five to thirty-nine, inclusive;

(2) A mammogram every year for women age forty and over;

(3) A mammogram for any woman, upon the recommendation of a physician, where such woman, her mother or her sister has a prior history of breast cancer.

3. Coverage and benefits related to mammography as required by this section shall be at least as favorable and subject to the same dollar limits, deductibles, and co-payments as other radiological examinations; provided, however, that on and after January 1, 2019, providers of low-dose mammography screening shall be reimbursed at rates accurately reflecting the resource costs specific to each modality, including any increased resource cost of breast tomosynthesis.

4. The provisions of 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) Coverage for medication-assisted treatment for substance use disorders for use in treating such patient's condition, including opioid-use and heroin-use disorders;

(5) 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

(6) 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.

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

(1) Notwithstanding the provisions of subsection 4 of section 354.618, provide enrollees with direct access to the services of a participating obstetrician, participating gynecologist or participating obstetrician/gynecologist of her choice within the provider network for covered services. The services covered by this subdivision shall be limited to those services defined by the published recommendations of the accreditation council for graduate medical education for training an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to diagnosis, treatment and referral for such services. A health carrier shall not impose additional co-payments, coinsurance or deductibles upon any enrollee who seeks or receives health care services pursuant to this subdivision, unless similar additional co-payments, coinsurance or deductibles are imposed for other types of health care services received within the provider network. Nothing in this subsection shall be construed to require a health carrier to perform, induce, pay for, reimburse, guarantee, arrange, provide any resources for or refer a patient for an abortion, as defined in section 188.015, other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed, or to supersede or conflict with section 376.805; and

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

(3) Include coverage for services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice

medicine and surgery in this state, for individuals with a condition or medical history for which bone mass measurement is medically indicated for such individual. In determining whether testing or treatment is medically appropriate, due consideration shall be given to peer-reviewed medical literature. A policy, provision, contract, plan or agreement may apply to such services the same deductibles, coinsurance and other limitations as apply to other covered services; and

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

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

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

3. The provisions of 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, 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.

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

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

(2) Upon request of an enrollee who is a member of a group health benefit plan and who states that the use or provision of contraceptives is contrary to his or her moral, ethical or religious beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that excludes coverage for contraceptives. Any administrative costs to a group health benefit plan

associated with such exclusion of coverage not offset by the decreased costs of providing coverage shall be borne by the group policyholder or group plan holder;

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

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

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

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

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

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

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

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

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

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

8. The departments of health and senior services and insurance, financial institutions and professional registration may promulgate rules necessary to implement the provisions of this

section. No rule or portion of a rule promulgated pursuant to this section shall become effective unless it has been promulgated pursuant to chapter 536. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking 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 of 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.

376.1209. 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 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 the surgical procedure known as a mastectomy, and which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1998, shall provide coverage for prosthetic devices or reconstructive surgery necessary to restore symmetry as recommended by the oncologist or primary care physician for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the same deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits with the exception that no time limit shall be imposed on an individual for the receipt of prosthetic devices or reconstructive surgery and if such individual changes his or her insurer, then the new policy subject to the federal Women's Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277), as amended, shall provide coverage consistent with the federal Women's Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277), as amended, and any regulations promulgated pursuant to such act.

2. As used in this section, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a physician licensed pursuant to chapter 334.

3. The provisions of 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**, short-term major medical policy having a duration of less than one year,** or long-term care policy.

376.1210. 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 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 are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1997, and providing for maternity benefits, shall provide coverage for a minimum of forty-eight hours of

inpatient care following a vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean section for a mother and her newly born child in a hospital as defined in section 197.020 or any other health care facility licensed to provide obstetrical care under the provisions of chapter 197.

2. Notwithstanding the provisions of subsection 1 of this section, any 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 are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1997, and providing for maternity benefits, may authorize a shorter length of hospital stay for services related to maternity and newborn care if:

(1) A shorter hospital stay meets with the approval of the attending physician after consulting with the mother. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization; and

(2) The entity providing the individual or group health insurance policy provides coverage for post-discharge care to the mother and her newborn.

3. Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending physician as medically appropriate.

4. For the purposes of this section, "attending physician" shall include the attending obstetrician, pediatrician, or other physician attending the mother or newly born child.

5. 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 shall provide notice to policyholders, insured persons and participants regarding the coverage required by this section. Such notice shall be in writing and prominently positioned in the policy, certificate of coverage or summary plan description.

6. Such health care service shall not be subject to any greater deductible or co-payment than other similar health care services provided by the policy, contract or plan.

7. No insurer may provide financial disincentives to, or deselect, terminate the services of, require additional documentation from, require additional utilization review, or reduce payments to, or otherwise penalize the attending physician in retaliation solely for ordering care consistent with the provisions of this section.

8. **The provisions of this section shall not apply to short-term major medical policies having a duration of less than one year.**

9. The department of insurance, financial institutions and professional registration shall adopt rules and regulations to implement and enforce the provisions of this section. No rule or portion of a rule promulgated pursuant to this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.

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

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

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

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

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

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

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

intervention system centers and providers, shall be considered the rendering provider of services for purposes of this section.

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

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

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

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

8. This section shall not apply to a supplemental insurance policy, including a life care contract, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, hospitalization-surgical care policy, policy that is individually underwritten

or provides such coverage for specific individuals and members of their families, long-term care policy, or short-term major medical policies **[**~~of six months or less duration~~**] having a duration of less than one year**.

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

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

376.1219. 1. Each policy issued by an entity offering individual and group health insurance which provides coverage on an expense-incurred basis, individual and group health 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 health arrangements to the extent not preempted by federal law, and all health care plans provided by 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 September 1, 1997, shall provide coverage for formula and low protein modified food products recommended by a physician for the treatment of a patient with phenylketonuria or any inherited disease of amino and organic acids who is covered under the policy, contract, or plan and who is less than six years of age.

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

3. The coverage required by this section may be subject to the same deductible for similar health care services provided by the policy, contract, or plan as well as a reasonable coinsurance or co-payment on the part of the insured, which shall not be greater than fifty percent of the cost of the formula and food products, and may be subject to an annual benefit maximum of not less than five thousand dollars per covered child. Nothing in this section shall prohibit a carrier from using individual case management or from contracting with vendors of the formula and food products.

4. 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, **short-term major medical policy 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.

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

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

3. 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, short-term major medical policies **[**~~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.

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

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

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

(2) "Autism service provider":

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

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

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

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

5. Coverage provided under this section for applied behavior analysis shall be subject to a maximum benefit of forty thousand dollars per calendar year for individuals through eighteen years of age. Such maximum benefit limit may be exceeded, upon prior approval by the health benefit plan, if the provision of applied behavior analysis services beyond the maximum limit is medically necessary for such individual. Payments made by a health carrier on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered

individual's autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection. Any coverage required under this section, other than the coverage for applied behavior analysis, shall not be subject to the age and dollar limitations described in this subsection.

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

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

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

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

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

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

Such payments or reimbursements under this subsection to an autism service provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a

line therapist under the supervision of such provider or behavior analyst if such services provided by the line therapist are included in the treatment plan and are deemed medically necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The total number of insureds diagnosed with autism spectrum disorder;

(b) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this section;

(c) The cost of such coverage per insured per month; and

(d) The average cost per insured for coverage of applied behavior analysis;

(2) All health carriers and health benefit plans subject to the provisions of this section shall provide the department with the data requested by the department for inclusion in the annual report.

376.1225. 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 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 are delivered, issued for delivery, continued or renewed on or after August 28, 1998, shall provide coverage for administration of general anesthesia and hospital charges for dental care provided to the following covered persons:

(1) A child under the age of five;

(2) A person who is severely disabled; or

(3) A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

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

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

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

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

2. A health benefit plan shall provide coverage for treatment of a chiropractic care 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 chiropractic care condition than for access to treatment for another physical health condition.

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

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

5. The provisions of 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, short-term major medical policy **[**~~of six months' or less duration~~**] having a duration of less than one year**, or any other similar supplemental policy.

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

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

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

4. The provisions of 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, short-term major medical policies **[**~~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.

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

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

3. Beginning September 1, 2016, the oversight division of the joint committee on legislative research shall perform an actuarial analysis of the cost impact to health carriers, insureds with a health benefit plan, and other private and public payers if the provisions of this

section regarding occupational therapy coverage were enacted. By December 31, 2016, the director of the oversight division of the joint committee on legislative research shall submit a report of the actuarial findings prescribed by this section to the speaker, the president pro tem, and the chairpersons of both the house of representatives and senate standing committees having jurisdiction over health insurance matters. If the fiscal note cost estimation is less than the cost of an actuarial analysis, the actuarial analysis requirement shall be waived.

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

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

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

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

4. The provisions of 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, short-term major medical policies **[**~~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.

376.1250. 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 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 are delivered, issued for delivery, continued or renewed on or after August 28, 1999, and providing coverage to any resident of this state shall provide benefits or coverage for:

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

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

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

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

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

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

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

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

376.1253. 1. Each physician attending any patient with a newly diagnosed cancer shall inform the patient that the patient has the right to a referral for a second opinion by an appropriate board-certified specialist prior to any treatment. If no specialist in that specific cancer diagnosis area is in the provider network, a referral shall be made to a nonnetwork specialist in accordance with this section.

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

3. The provisions of 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, short-term major medical policies **[**~~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.

376.1257. 1. As used in this section the following terms shall mean:

(1) "Anticancer medications", medications used to kill or slow the growth of cancerous cells;

(2) "Covered person", a policyholder, subscriber, enrollee, or other individual enrolled in or insured by a health benefit plan for health insurance coverage;

(3) "Health benefit plan", shall have the same meaning as defined in section 376.1350.

2. Any health benefit plan that provides coverage and benefits for cancer treatment shall provide coverage of prescribed orally administered anticancer medications on a basis no less favorable than intravenously administered or injected anticancer medications.

3. Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, co-payment, deductible, or other out-of-pocket expense that does not apply to intravenously administered or injected anticancer medication, regardless of formulation or benefit category determination by the company administering the health benefit plan.

4. The health benefit plan shall not reclassify or increase any type of cost-sharing to the covered person for anticancer medications in order to achieve compliance with this section. Any change in health insurance coverage, which otherwise increases an out-of-pocket expense to anticancer medications, shall be applied to the majority of comparable medical or pharmaceutical benefits covered by the health benefit plan.

5. Notwithstanding the provisions of subsections 2, 3, and 4 of this section, a health benefit plan that limits the total amounts paid by a covered person through all cost-sharing requirements to no more than seventy-five dollars per thirty-day supply for any orally administered anticancer medication shall be considered in compliance with this section. On January 1, 2016, and on January first of each year thereafter, a health benefit plan may adjust such seventy-five dollar limit. The adjustment shall not exceed the Consumer Price Index for All Urban Consumers Midwest Region for that year. For purposes of this subsection "cost-sharing requirements" shall include co-payments, coinsurance, deductibles, and any other amounts paid by the covered person for that prescription.

6. For a health benefit plan that meets the definition of "high deductible health plan" as defined by 26 U.S.C. 223(c)(2), the provisions of subsection 5 of this section shall only apply after a covered person's deductible has been satisfied for the year.

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

8. The provisions of this section shall become effective January 1, 2015.

376.1275. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2003, shall include coverage for their members for the cost for human leukocyte

antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists. At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor Program. The health benefit plan may limit each enrollee to one such testing per lifetime to be reimbursed at a cost of no greater than seventy-five dollars by the health carrier or health benefit plan.

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

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

4. The provisions of 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, short-term major medical policies **[**~~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.

376.1290. 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, 2002, shall offer coverage for testing pregnant women for lead poisoning and for all testing for lead poisoning authorized by sections 701.340 to 701.349 or by rule of the department of health and senior services promulgated pursuant to sections 701.340 to 701.349.

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

3. No entity enumerated in subsection 1 of this section shall reduce or eliminate coverage as a result of the requirements of this section.

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

376.1345. 1. As used in this section, unless the context clearly indicates otherwise, terms shall have the same meaning as ascribed to them in section 376.1350.

2. No health carrier, nor any entity acting on behalf of a health carrier, shall restrict methods of reimbursement to health care providers for health care services to a reimbursement method requiring the provider to pay a fee, discount the amount of their claim for reimbursement, or remit any other form of remuneration in order to redeem the amount of their claim for reimbursement.

3. If a health carrier initiates or changes the method used to reimburse a health care provider to a method of reimbursement that will require the health care provider to pay a fee, discount the amount of its claim for reimbursement, or remit any other form of remuneration to the health carrier or any entity acting on behalf of the health carrier in order to redeem the amount of its claim for reimbursement, the health carrier or an entity acting on its behalf shall:

(1) Notify such health care, provider of the fee, discount, or other remuneration required to received reimbursement through the new or different reimbursement method; and

(2) In such notice, provide clear instructions to the health care provider as to how to select an alternative payment method, and upon request such alternative payment method shall be used to reimburse the provider until the provider requests otherwise.

4. A health carrier shall allow the provider to select to be reimbursed by an electronic funds transfer though the Automated Clearing House Network as required pursuant to 45 C.F.R. Sections 162.925, 162.1601, and 162.1602.

5. Violation of this section shall be deemed an unfair trade practice under sections 375.930 to 375.948.

376.1400. 1. Every health insurance carrier offering policies of insurance in this state shall use standardized information 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, short-term major medical policies **[**~~of six months or less duration~~**] having a duration of less than one year**, 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 is 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 or occupational role functioning or both;

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

3. This section shall not apply to a health plan or policy that is individually underwritten or provides such coverage for specific individuals and members of their families pursuant to section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836, 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 policies **[**~~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.

4. Notwithstanding any other provision of law to the contrary, all health insurance policies that cover state employees, including the Missouri consolidated health care plan, shall

include coverage for mental illness. Multiyear group policies need not comply until the expiration of their current multiyear term unless the policyholder elects to comply before that time.

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

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

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

(3) Care that is custodial in nature;

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

(5) Treatments that are considered experimental.

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

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

(1) "Electronic visit", or "e-visit", an online electronic medical evaluation and management service completed using a secured web-based or similar electronic-based communications network for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of a patient with the health care provider, be completed using a federal Health Insurance Portability and Accountability Act (HIPAA)-compliant online connection, and include a permanent record of the electronic visit;

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

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

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

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

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

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

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

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

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

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

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

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

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

10. The provisions of 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, short-term major medical policies **[**~~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.

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