

SECOND REGULAR SESSION

SENATE BILL NO. 836

100TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR ONDER.

Read 1st time January 8, 2020, and ordered printed.

ADRIANE D. CROUSE, Secretary.

4415S.011

AN ACT

To repeal sections 191.671, 376.385, 376.429, 376.446, 376.452, 376.454, 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-four new sections relating to short-term major medical insurance policies.

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

Section A. Sections 191.671, 376.385, 376.429, 376.446, 376.452, 376.454, 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376.1235, 376.1237, 376.1250, 376.1253, 376.1257, 376.1275, 376.1290, 376.1400, 376.1550, and 376.1900, RSMo, are repealed and thirty-four new sections enacted in lieu thereof, to be known as sections 191.671, 376.008, 376.385, 376.429, 376.446, 376.452, 376.454, 376.779, 376.781,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, to read as follows:

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 commerce and insurance 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

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

6 that nothing in this section shall be construed to exempt any insurer, health
7 services corporation or health maintenance organization in their capacity as
8 employers from the provisions of section 191.665 relating to employment
9 practices.

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

21 3. The director of the department of commerce and insurance shall
22 establish by regulation standards for the use of HIV testing by insurers, health
23 services corporations and health maintenance organizations.

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

32 5. The result or results of HIV testing of an applicant for insurance
33 coverage shall not be disclosed by an insurer, health services corporation or
34 health maintenance organization, except as specifically authorized by such
35 applicant in writing. Such result or results shall, however, be disclosed to a
36 physician designated by the subject of the test. If there is no physician
37 designated, the insurer, health services corporation, or health maintenance
38 organization shall disclose the identity of individuals residing in Missouri having
39 a confirmed positive HIV test result to the department of health and senior
40 services. Provided, further, that no such insurer, health services corporation or
41 health maintenance organization shall be liable for violating any duty or right of

42 confidentiality established by law for disclosing such identity of individuals
43 having a confirmed positive HIV test result to the department of health and
44 senior services. Such disclosure shall be in a manner that ensures
45 confidentiality. Disclosure of test results in violation of this section shall
46 constitute a violation of sections 375.930 to 375.948 regulating trade practices in
47 the business of insurance. Nothing in this subsection shall be construed to
48 foreclose any remedies existing on June 1, 1988.

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

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

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

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

21 **(a) Each occurrence;**

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

26 **(c) Each contract period;**

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

29 **(a) Inpatient hospital care;**

30 **(b) Outpatient hospital care;**

- 31 (c) **Nonhospital inpatient care;**
32 (d) **Nonhospital outpatient care;**
33 (e) **Prescription drugs; and**
34 (f) **Emergency services; and**
35 (3) **Any co-payment or deductible for an illness or affliction**
36 **which differs from the co-payment or deductible required to be**
37 **described under subdivision (2) of this subsection.**

376.385. 1. Each entity offering individual and group health insurance
2 policies providing coverage on an expense-incurred basis, individual and group
3 service or indemnity type contracts issued by a health services corporation,
4 individual and group service contracts issued by a health maintenance
5 organization, all self-insured group arrangements, to the extent not preempted
6 by federal law, and all managed health care delivery entities of any type or
7 description, that are delivered, issued for delivery, continued or renewed in this
8 state on or after January 1, 1998, shall offer coverage for all physician-prescribed
9 medically appropriate and necessary equipment, supplies and self-management
10 training used in the management and treatment of diabetes. Coverage shall
11 include persons with gestational, type I or type II diabetes.

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

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

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

376.429. 1. All health benefit plans, as defined in section 376.1350, that
2 are delivered, issued for delivery, continued or renewed on or after August 28,
3 2006, and providing coverage to any resident of this state shall provide coverage
4 for routine patient care costs as defined in subsection 7 of this section incurred
5 as the result of phase II, III, or IV of a clinical trial that is approved by an entity
6 listed in subsection 4 of this section and is undertaken for the purposes of the
7 prevention, early detection, or treatment of cancer. Health benefit plans may
8 limit coverage for the routine patient care costs of patients in phase II of a
9 clinical trial to those treating facilities within the health benefit plans' provider

10 network; except that, this provision shall not be construed as relieving a health
11 benefit plan of the sufficiency of network requirements under state statute.

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

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

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

- 27 (1) One of the National Institutes of Health (NIH);
28 (2) An NIH cooperative group or center as defined in subsection 7 of this
29 section;
30 (3) The FDA in the form of an investigational new drug application;
31 (4) The federal Departments of Veterans' Affairs or Defense;
32 (5) An institutional review board in this state that has an appropriate
33 assurance approved by the Department of Health and Human Services assuring
34 compliance with and implementation of regulations for the protection of human
35 subjects (45 CFR 46); or
36 (6) A qualified research entity that meets the criteria for NIH Center
37 support grant eligibility.

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

- 40 (1) Phase II of a clinical trial is sanctioned by the National Institutes of
41 Health (NIH) or National Cancer Institute (NCI) and conducted at academic or
42 National Cancer Institute Center; and
43 (2) The person covered under this section is enrolled in the clinical
44 trial. This section shall not apply to persons who are only following the protocol
45 of phase II of a clinical trial, but not actually enrolled.

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

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

56 (1) "Cooperative group", a formal network of facilities that collaborate on
57 research projects and have an established NIH-approved Peer Review Program
58 operating within the group, including the NCI Clinical Cooperative Group and the
59 NCI Community Clinical Oncology Program;

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

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

70 (a) The investigational item or service itself;

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

74 (c) Items and services customarily provided by the research sponsors free
75 of charge for any enrollee in the trial.

76 8. For the purpose of this section, providers participating in clinical trials
77 shall obtain a patient's informed consent for participation on the clinical trial in
78 a manner that is consistent with current legal and ethical standards. Such
79 documents shall be made available to the health insurer upon request.

80 9. The provisions of this section shall not apply to a policy, plan or
81 contract paid under Title XVIII or Title XIX of the Social Security Act.

82 10. Nothing in this section shall apply to any accident-only policy,
83 specified disease policy, hospital indemnity policy, Medicare supplement policy,
84 long-term care policy, short-term major medical policy [of six months or less
85 duration] **having a duration of less than one year**, or other limited benefit
86 health insurance policies.

87 11. The provisions of this section regarding phase II of a clinical trial
88 shall not apply automatically to an individually underwritten health benefit plan,
89 but shall be an option to any such plan.

376.446. 1. Health carriers shall permit individuals to learn the amount
2 of cost-sharing, including deductibles, [copayments] **co-payments**, and
3 coinsurance, under the individual's health benefit plan or coverage that the
4 individual would be responsible for paying with respect to the furnishing of a
5 specific item or service by a participating provider in a timely manner upon the
6 request of the individual. At a minimum, such information shall be made
7 available to such individual through an internet website and such other means
8 for individuals without access to the internet. As used in this section, the terms
9 "health carrier" and "health benefit plans" shall have the same meanings
10 assigned to them in section 376.1350.

11 2. **Health carriers shall permit individuals to learn the amount**
12 **of cost-sharing, including deductibles, co-payments, and coinsurance,**
13 **under an individual's short-term major medical policy, having a**
14 **duration of less than one year, that the individual would be responsible**
15 **for paying with respect to the furnishing of a specific item or service**
16 **by a participating provider in a timely manner upon the request of the**
17 **individual. At a minimum, such information shall be made available to**
18 **such individual through an internet website and such other means for**
19 **individuals without access to the internet.**

20 3. This section shall not apply to a supplemental insurance policy,
21 including a life care contract, accident-only policy, specified disease policy,
22 hospital policy providing a fixed daily benefit only, Medicare supplement policy,
23 long-term care policy, hospitalization-surgical care policy, short-term major
24 medical policy of six months or less duration, or any other supplemental policy.

25 [3.] 4. The provisions of subsections 1 and [2] **3** shall become effective on
26 January 1, 2014.

376.452. 1. Except as provided in this section, if a health insurance issuer
2 offers health insurance coverage in the large group market in connection with a

3 group health plan, the health insurance issuer shall renew or continue the
4 coverage in force at the option of the plan sponsor. **The provisions of this**
5 **subsection shall not apply to short-term major medical policies having**
6 **a duration of less than one year.**

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

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

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

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

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

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

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

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

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

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

38 (2) The issuer offers to each plan sponsor being provided coverage of this

39 type in the large group market the option to purchase any other health insurance
40 coverage currently being offered by the health insurance issuer to a group health
41 plan in the large group market; and

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

46 4. (1) A health insurance issuer shall not discontinue offering all health
47 insurance coverage in the large group market unless:

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

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

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

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

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

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

6 2. A health insurance issuer may nonrenew or discontinue health

7 insurance coverage of an individual in the individual market based only on one
8 or more of the following:

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

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

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

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

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

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

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

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

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

43 4. (1) In any case in which a health insurance issuer elects to discontinue
44 offering all health insurance coverage in the individual market in the state,
45 health insurance coverage may be discontinued by the issuer only if:

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

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

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

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

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

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

376.779. 1. All health plans or policies that are individually underwritten
2 or provide for such coverage for specific individuals and the members of their
3 families, which provide for hospital treatment, shall provide coverage, while
4 confined in a hospital or in a residential or nonresidential facility certified by the
5 department of mental health, for treatment of alcoholism on the same basis as
6 coverage for any other illness, except that coverage may be limited to thirty days
7 in any policy or contract benefit period. All Missouri individual contracts issued
8 on or after January 1, 2005, shall be subject to this section. Coverage required
9 by this section shall be included in the policy or contract and payment provided

10 as for other coverage in the same policy or contract notwithstanding any
11 construction or relationship of interdependent contracts or plans affecting
12 coverage and payment of reimbursement prerequisites under the policy or
13 contract.

14 2. Insurers, corporations or groups providing coverage may approve for
15 payment or reimbursement vendors and programs providing services or treatment
16 required by this section. Any vendor or person offering services or treatment
17 subject to the provisions of this section and seeking approval for payment or
18 reimbursement shall submit to the department of mental health a detailed
19 description of the services or treatment program to be offered. The department
20 of mental health shall make copies of such descriptions available to insurers,
21 corporations or groups providing coverage under the provisions of this
22 section. Each insurer, corporation or group providing coverage shall notify the
23 vendor or person offering service or treatment as to its acceptance or rejection for
24 payment or reimbursement; provided, however, payment or reimbursement shall
25 be made for any service or treatment program certified by the department of
26 mental health. Any notice of rejection shall contain a detailed statement of the
27 reasons for rejection and the steps and procedures necessary for
28 acceptance. Amended descriptions of services or treatment programs to be offered
29 may be filed with the department of mental health. Any vendor or person
30 rejected for approval of payment or reimbursement may modify their description
31 and treatment program and submit copies of the amended description to the
32 department of mental health and to the insurer, corporation or group which
33 rejected the original description.

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

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

41 5. This section shall not apply to a supplemental insurance policy,
42 including a life care contract, accident-only policy, specified disease policy,
43 hospital policy providing a fixed daily benefit only, Medicare supplement policy,
44 long-term care policy, hospitalization-surgical care policy, short-term major
45 medical policy [of six months or less duration] **having a duration of less than**

46 **one year**, or any other supplemental policy as determined by the director of the
47 department of commerce and insurance.

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

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

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

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

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

32 6. The department of commerce and insurance may issue rules necessary
33 to carry out the provisions of this section. No rule or portion of a rule
34 promulgated under the authority of this section shall become effective unless it

35 has been promulgated pursuant to the provisions of section 536.024.

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

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

13 2. All individual and group health insurance policies providing coverage
14 on an expense-incurred basis, individual and group service or indemnity type
15 contracts issued by a nonprofit corporation, individual and group service contracts
16 issued by a health maintenance organization, all self-insured group arrangements
17 to the extent not preempted by federal law and all managed health care delivery
18 entities of any type or description, that are delivered, issued for delivery,
19 continued or renewed on or after August 28, 1991, and providing coverage to any
20 resident of this state shall provide benefits or coverage for low-dose
21 mammography screening for any nonsymptomatic woman covered under such
22 policy or contract which meets the minimum requirements of this section. Such
23 benefits or coverage shall include at least the following:

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

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

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

30 3. Coverage and benefits related to mammography as required by this
31 section shall be at least as favorable and subject to the same dollar limits,
32 deductibles, and co-payments as other radiological examinations; provided,
33 however, that on and after January 1, 2019, providers of low-dose mammography

34 screening shall be reimbursed at rates accurately reflecting the resource costs
35 specific to each modality, including any increased resource cost of breast
36 tomosynthesis.

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

376.811. 1. Every insurance company and health services corporation
2 doing business in this state shall offer in all health insurance policies benefits or
3 coverage for chemical dependency meeting the following minimum standards:

4 (1) Coverage for outpatient treatment through a nonresidential treatment
5 program, or through partial- or full-day program services, of not less than
6 twenty-six days per policy benefit period;

7 (2) Coverage for residential treatment program of not less than
8 twenty-one days per policy benefit period;

9 (3) Coverage for medical or social setting detoxification of not less than
10 six days per policy benefit period;

11 (4) Coverage for medication-assisted treatment for substance use disorders
12 for use in treating such patient's condition, including opioid-use and heroin-use
13 disorders;

14 (5) The coverages set forth in this subsection may be subject to a separate
15 lifetime frequency cap of not less than ten episodes of treatment, except that such
16 separate lifetime frequency cap shall not apply to medical detoxification in a
17 life-threatening situation as determined by the treating physician and
18 subsequently documented within forty-eight hours of treatment to the reasonable
19 satisfaction of the insurance company or health services corporation; and

20 (6) The coverages set forth in this subsection:

21 (a) Shall be subject to the same coinsurance, co-payment and deductible
22 factors as apply to physical illness;

23 (b) May be administered pursuant to a managed care program established
24 by the insurance company or health services corporation; and

25 (c) May deliver covered services through a system of contractual
26 arrangements with one or more providers, hospitals, nonresidential or residential
27 treatment programs, or other mental health service delivery entities certified by
28 the department of mental health, or accredited by a nationally recognized
29 organization, or licensed by the state of Missouri.

30 2. In addition to the coverages set forth in subsection 1 of this section,
31 every insurance company, health services corporation and health maintenance

32 organization doing business in this state shall offer in all health insurance
33 policies, benefits or coverages for recognized mental illness, excluding chemical
34 dependency, meeting the following minimum standards:

35 (1) Coverage for outpatient treatment, including treatment through
36 partial- or full-day program services, for mental health services for a recognized
37 mental illness rendered by a licensed professional to the same extent as any other
38 illness;

39 (2) Coverage for residential treatment programs for the therapeutic care
40 and treatment of a recognized mental illness when prescribed by a licensed
41 professional and rendered in a psychiatric residential treatment center licensed
42 by the department of mental health or accredited by the Joint Commission on
43 Accreditation of Hospitals to the same extent as any other illness;

44 (3) Coverage for inpatient hospital treatment for a recognized mental
45 illness to the same extent as for any other illness, not to exceed ninety days per
46 year;

47 (4) The coverages set forth in this subsection shall be subject to the same
48 coinsurance, co-payment, deductible, annual maximum and lifetime maximum
49 factors as apply to physical illness; and

50 (5) The coverages set forth in this subsection may be administered
51 pursuant to a managed care program established by the insurance company,
52 health services corporation or health maintenance organization, and covered
53 services may be delivered through a system of contractual arrangements with one
54 or more providers, community mental health centers, hospitals, nonresidential or
55 residential treatment programs, or other mental health service delivery entities
56 certified by the department of mental health, or accredited by a nationally
57 recognized organization, or licensed by the state of Missouri.

58 3. The offer required by sections 376.810 to 376.814 may be accepted or
59 rejected by the group or individual policyholder or contract holder and, if
60 accepted, shall fully and completely satisfy and substitute for the coverage under
61 section 376.779. Nothing in sections 376.810 to 376.814 shall prohibit an
62 insurance company, health services corporation or health maintenance
63 organization from including all or part of the coverages set forth in sections
64 376.810 to 376.814 as standard coverage in their policies or contracts issued in
65 this state.

66 4. Every insurance company, health services corporation and health
67 maintenance organization doing business in this state shall offer in all health

68 insurance policies mental health benefits or coverage as part of the policy or as
69 a supplement to the policy. Such mental health benefits or coverage shall include
70 at least two sessions per year to a licensed psychiatrist, licensed psychologist,
71 licensed professional counselor, licensed clinical social worker, or, subject to
72 contractual provisions, a licensed marital and family therapist, acting within the
73 scope of such license and under the following minimum standards:

74 (1) Coverage and benefits in this subsection shall be for the purpose of
75 diagnosis or assessment, but not dependent upon findings; and

76 (2) Coverage and benefits in this subsection shall not be subject to any
77 conditions of preapproval, and shall be deemed reimbursable as long as the
78 provisions of this subsection are satisfied; and

79 (3) Coverage and benefits in this subsection shall be subject to the same
80 coinsurance, co-payment and deductible factors as apply to regular office visits
81 under coverages and benefits for physical illness.

82 5. If the group or individual policyholder or contract holder rejects the
83 offer required by this section, then the coverage shall be governed by the mental
84 health and chemical dependency insurance act as provided in sections 376.825 to
85 376.836.

86 6. This section shall not apply to a supplemental insurance policy,
87 including a life care contract, accident-only policy, specified disease policy,
88 hospital policy providing a fixed daily benefit only, Medicare supplement policy,
89 long-term care policy, hospitalization-surgical care policy, short-term major
90 medical policy [of six months or less duration] **having a duration of less than**
91 **one year**, or any other supplemental policy as determined by the director of the
92 department of commerce and insurance.

376.845. 1. For the purposes of this section the following terms shall
2 mean:

3 (1) "Eating disorder", pica, rumination disorder, avoidant/restrictive food
4 intake disorder, anorexia nervosa, bulimia nervosa, binge eating disorder, other
5 specified feeding or eating disorder, and any other eating disorder contained in
6 the most recent version of the Diagnostic and Statistical Manual of Mental
7 Disorders published by the American Psychiatric Association where diagnosed by
8 a licensed physician, psychiatrist, psychologist, clinical social worker, licensed
9 marital and family therapist, or professional counselor duly licensed in the state
10 where he or she practices and acting within their applicable scope of practice in
11 the state where he or she practices;

12 (2) "Health benefit plan", shall have the same meaning as such term is
13 defined in section 376.1350; however, for purposes of this section "health benefit
14 plan" does not include a supplemental insurance policy, including a life care
15 contract, accident-only policy, specified disease policy, hospital policy providing
16 a fixed daily benefit only, Medicare supplement policy, long-term care policy,
17 short-term major medical policy [of six months or less duration] **having a**
18 **duration of less than one year**, or any other supplemental policy;

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

21 (4) "Medical care", health care services needed to diagnose, prevent, treat,
22 cure, or relieve physical manifestations of an eating disorder, and shall include
23 inpatient hospitalization, partial hospitalization, residential care, intensive
24 outpatient treatment, follow-up outpatient care, and counseling;

25 (5) "Pharmacy care", medications prescribed by a licensed physician for
26 an eating disorder and includes any health-related services deemed medically
27 necessary to determine the need or effectiveness of the medications, but only to
28 the extent that such medications are included in the insured's health benefit
29 plan;

30 (6) "Psychiatric care" and "psychological care", direct or consultative
31 services provided during inpatient hospitalization, partial hospitalization,
32 residential care, intensive outpatient treatment, follow-up outpatient care, and
33 counseling provided by a psychiatrist or psychologist licensed in the state of
34 practice;

35 (7) "Therapy", medical care and behavioral interventions provided by a
36 duly licensed physician, psychiatrist, psychologist, professional counselor, licensed
37 clinical social worker, or family marriage therapist where said person is licensed
38 or registered in the states where he or she practices;

39 (8) "Treatment of eating disorders", therapy provided by a licensed
40 treating physician, psychiatrist, psychologist, professional counselor, clinical
41 social worker, or licensed marital and family therapist pursuant to the powers
42 granted under such licensed physician's, psychiatrist's, psychologist's,
43 professional counselor's, clinical social worker's, or licensed marital and family
44 therapist's [license] **licensed** in the state where he or she practices for an
45 individual diagnosed with an eating disorder.

46 2. In accordance with the provisions of section 376.1550, all health benefit
47 plans that are delivered, issued for delivery, continued or renewed on or after

48 January 1, 2017, if written inside the state of Missouri, or written outside the
49 state of Missouri but covering Missouri residents, shall provide coverage for the
50 diagnosis and treatment of eating disorders as required in section 376.1550.

51 3. Coverage provided under this section is limited to medically necessary
52 treatment that is provided by a licensed treating physician, psychiatrist,
53 psychologist, professional counselor, clinical social worker, or licensed marital and
54 family therapist pursuant to the powers granted under such licensed physician's,
55 psychiatrist's, psychologist's, professional counselor's, clinical social worker's, or
56 licensed marital and family therapist's license and acting within their applicable
57 scope of coverage, in accordance with a treatment plan.

58 4. The treatment plan, upon request by the health benefit plan or health
59 carrier, shall include all elements necessary for the health benefit plan or health
60 carrier to pay claims. Such elements include, but are not limited to, a diagnosis,
61 proposed treatment by type, frequency and duration of treatment, and goals.

62 5. Coverage of the treatment of eating disorders may be subject to other
63 general exclusions and limitations of the contract or benefit plan not in conflict
64 with the provisions of this section, such as coordination of benefits, and
65 utilization review of health care services, which includes reviews of medical
66 necessity and care management. Medical necessity determinations and care
67 management for the treatment of eating disorders shall consider the overall
68 medical and mental health needs of the individual with an eating disorder, shall
69 not be based solely on weight, and shall take into consideration the most recent
70 Practice Guideline for the Treatment of Patients with Eating Disorders adopted
71 by the American Psychiatric Association in addition to current standards based
72 upon the medical literature generally recognized as authoritative in the medical
73 community.

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

5 (1) Notwithstanding the provisions of subsection 4 of section 354.618,
6 provide enrollees with direct access to the services of a participating obstetrician,
7 participating gynecologist or participating obstetrician/gynecologist of her choice
8 within the provider network for covered services. The services covered by this
9 subdivision shall be limited to those services defined by the published
10 recommendations of the accreditation council for graduate medical education for

11 training an obstetrician, gynecologist or obstetrician/gynecologist, including but
12 not limited to diagnosis, treatment and referral for such services. A health
13 carrier shall not impose additional co-payments, coinsurance or deductibles upon
14 any enrollee who seeks or receives health care services pursuant to this
15 subdivision, unless similar additional co-payments, coinsurance or deductibles are
16 imposed for other types of health care services received within the provider
17 network. Nothing in this subsection shall be construed to require a health carrier
18 to perform, induce, pay for, reimburse, guarantee, arrange, provide any resources
19 for or refer a patient for an abortion, as defined in section 188.015, other than a
20 spontaneous abortion or to prevent the death of the female upon whom the
21 abortion is performed, or to supersede or conflict with section 376.805; and

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

28 (3) Include coverage for services related to diagnosis, treatment and
29 appropriate management of osteoporosis when such services are provided by a
30 person licensed to practice medicine and surgery in this state, for individuals
31 with a condition or medical history for which bone mass measurement is
32 medically indicated for such individual. In determining whether testing or
33 treatment is medically appropriate, due consideration shall be given to
34 peer-reviewed medical literature. A policy, provision, contract, plan or agreement
35 may apply to such services the same deductibles, coinsurance and other
36 limitations as apply to other covered services; and

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

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

47 health care provider with prescriptive authority for reasons other than
48 contraceptive or abortion purposes.

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

51 3. The provisions of this section shall not apply to a supplemental
52 insurance policy, including a life care contract, accident-only policy, specified
53 disease policy, hospital policy providing a fixed daily benefit only, Medicare
54 supplement policy, long-term care policy, short-term major medical [policies of six
55 months or less duration] **policy having a duration of less than one year**, or
56 any other supplemental policy as determined by the director of the department
57 of commerce and insurance.

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

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

64 (2) Upon request of an enrollee who is a member of a group health benefit
65 plan and who states that the use or provision of contraceptives is contrary to his
66 or her moral, ethical or religious beliefs, any health carrier shall issue to or on
67 behalf of such enrollee a policy form that excludes coverage for
68 contraceptives. Any administrative costs to a group health benefit plan
69 associated with such exclusion of coverage not offset by the decreased costs of
70 providing coverage shall be borne by the group policyholder or group plan holder;

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

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

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

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

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

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

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

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

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

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

110 8. The departments of health and senior services and insurance, financial
111 institutions and professional registration may promulgate rules necessary to
112 implement the provisions of this section. No rule or portion of a rule promulgated
113 pursuant to this section shall become effective unless it has been promulgated
114 pursuant to chapter 536. Any rule or portion of a rule, as that term is defined in
115 section 536.010, that is created under the authority delegated in this section shall
116 become effective only if it complies with and is subject to all of the provisions of
117 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
118 nonseverable and if any of the powers vested with the general assembly pursuant

119 to chapter 536 to review, to delay the effective date or to disapprove and annul
120 a rule are subsequently held unconstitutional, then the grant of rulemaking
121 authority and any rule proposed or adopted after August 28, 2001, shall be
122 invalid and void.

376.1200. 1. Each entity offering individual and group health insurance
2 policies providing coverage on an expense-incurred basis, individual and group
3 service or indemnity type contracts issued by a health services corporation,
4 individual and group service contracts issued by a health maintenance
5 organization, all self-insured group arrangements to the extent not preempted by
6 federal law and all managed health care delivery entities of any type or
7 description, that are delivered, issued for delivery, continued or renewed in this
8 state on or after January 1, 1996, shall offer coverage for the treatment of breast
9 cancer by dose-intensive chemotherapy/autologous bone marrow transplants or
10 stem cell transplants when performed pursuant to nationally accepted peer
11 review protocols utilized by breast cancer treatment centers experienced in
12 dose-intensive chemotherapy/autologous bone marrow transplants or stem cell
13 transplants. The offer of benefits under this section shall be in writing and must
14 be accepted in writing by the individual or group policyholder or contract holder.

15 2. Such health care service shall not be subject to any greater deductible
16 or co-payment than any other health care service provided by the policy, contract
17 or plan, except that the policy, contract or plan may contain a provision imposing
18 a lifetime benefit maximum of not less than one hundred thousand dollars, for
19 dose-intensive chemotherapy/autologous bone marrow transplants or stem cell
20 transplants for breast cancer treatment.

21 3. Benefits may be administered for such health care service through a
22 managed care program of exclusive and/or preferred contractual arrangements
23 with one or more providers rendering such health care service. These contractual
24 arrangements may provide that the provider shall hold the patient harmless for
25 the cost of rendering such health care service if it is subsequently found by the
26 entity authorized to resolve disputes that:

27 (1) Such care did not qualify under the protocols established for the
28 providing of care for such health care service;

29 (2) Such care was not medically appropriate; or

30 (3) The provider otherwise failed to comply with the utilization
31 management or other managed care provision agreed to in any contract between
32 the entity and the provider.

33 4. The provisions of this section shall not apply to short-term travel,
34 accident-only, limited or specified disease policies, or to short-term nonrenewable
35 policies [of not more than seven months duration] **having a duration of less**
36 **than one year.**

37 5. Nothing in this section shall prohibit an entity from including all or
38 part of such health care services as standard coverage in its policies, contracts or
39 plans.

376.1209. 1. Each entity offering individual and group health insurance
2 policies providing coverage on an expense-incurred basis, individual and group
3 service or indemnity type contracts issued by a nonprofit corporation, individual
4 and group service contracts issued by a health maintenance organization, all
5 self-insured group arrangements to the extent not preempted by federal law, and
6 all managed health care delivery entities of any type or description, that provide
7 coverage for the surgical procedure known as a mastectomy, and which are
8 delivered, issued for delivery, continued or renewed in this state on or after
9 January 1, 1998, shall provide coverage for prosthetic devices or reconstructive
10 surgery necessary to restore symmetry as recommended by the oncologist or
11 primary care physician for the patient incident to the mastectomy. Coverage for
12 prosthetic devices and reconstructive surgery shall be subject to the same
13 deductible and coinsurance conditions applied to the mastectomy and all other
14 terms and conditions applicable to other benefits with the exception that no time
15 limit shall be imposed on an individual for the receipt of prosthetic devices or
16 reconstructive surgery and if such individual changes his or her insurer, then the
17 new policy subject to the federal Women's Health and Cancer Rights Act (Sections
18 901-903 of P.L. 105-277), as amended, shall provide coverage consistent with the
19 federal Women's Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277),
20 as amended, and any regulations promulgated pursuant to such act.

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

24 3. The provisions of this section shall not apply to a supplemental
25 insurance policy, including a life care contract, accident-only policy, specified
26 disease policy, hospital policy providing a fixed daily benefit only, Medicare
27 supplement policy, **short-term major medical policy having a duration of**
28 **less than one year,** or long-term care policy.

376.1210. 1. Each entity offering individual and group health insurance

2 policies providing coverage on an expense-incurred basis, individual and group
3 service or indemnity type contracts issued by a nonprofit corporation, individual
4 and group service contracts issued by a health maintenance organization, all
5 self-insured group arrangements to the extent not preempted by federal law, and
6 all managed health care delivery entities of any type or description, that are
7 delivered, issued for delivery, continued or renewed in this state on or after
8 January 1, 1997, and providing for maternity benefits, shall provide coverage for
9 a minimum of forty-eight hours of inpatient care following a vaginal delivery and
10 a minimum of ninety-six hours of inpatient care following a cesarean section for
11 a mother and her newly born child in a hospital as defined in section 197.020 or
12 any other health care facility licensed to provide obstetrical care under the
13 provisions of chapter 197.

14 2. Notwithstanding the provisions of subsection 1 of this section, any
15 entity offering individual and group health insurance policies providing coverage
16 on an expense-incurred basis, individual and group service or indemnity type
17 contracts issued by a nonprofit corporation, individual and group service contracts
18 issued by a health maintenance organization, all self-insured group arrangements
19 to the extent not preempted by federal law, and all managed health care delivery
20 entities of any type or description that are delivered, issued for delivery,
21 continued or renewed in this state on or after January 1, 1997, and providing for
22 maternity benefits, may authorize a shorter length of hospital stay for services
23 related to maternity and newborn care if:

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

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

32 3. Post-discharge care shall consist of a minimum of two visits at least one
33 of which shall be in the home, in accordance with accepted maternal and neonatal
34 physical assessments, by a registered professional nurse with experience in
35 maternal and child health nursing or a physician. The location and schedule of
36 the post-discharge visits shall be determined by the attending physician. Services
37 provided by the registered professional nurse or physician shall include, but not

38 be limited to, physical assessment of the newborn and mother, parent education,
39 assistance and training in breast or bottle feeding, education and services for
40 complete childhood immunizations, the performance of any necessary and
41 appropriate clinical tests and submission of a metabolic specimen satisfactory to
42 the state laboratory. Such services shall be in accordance with the medical
43 criteria outlined in the most current version of the "Guidelines for Perinatal
44 Care" prepared by the American Academy of Pediatrics and the American College
45 of Obstetricians and Gynecologists, or similar guidelines prepared by another
46 nationally recognized medical organization. Any abnormality, in the condition of
47 the mother or the child, observed by the nurse shall be reported to the attending
48 physician as medically appropriate.

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

52 5. Each entity offering individual and group health insurance policies
53 providing coverage on an expense-incurred basis, individual and group service or
54 indemnity type contracts issued by a nonprofit corporation, individual and group
55 service contracts issued by a health maintenance organization, all self-insured
56 group arrangements to the extent not preempted by federal law and all managed
57 health care delivery entities of any type or description shall provide notice to
58 policyholders, insured persons and participants regarding the coverage required
59 by this section. Such notice shall be in writing and prominently positioned in the
60 policy, certificate of coverage or summary plan description.

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

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

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

71 9. The department of commerce and insurance shall adopt rules and
72 regulations to implement and enforce the provisions of this section. No rule or
73 portion of a rule promulgated pursuant to this section shall become effective

74 unless it has been promulgated pursuant to the provisions of section 536.024.

376.1215. 1. All individual and group health insurance policies providing
2 coverage on an expense-incurred basis, individual and group service or indemnity
3 type contracts issued by a health services corporation, individual and group
4 service contracts issued by a health maintenance organization and all self-insured
5 group arrangements to the extent not preempted by federal law and all managed
6 health care delivery entities of any type or description shall provide coverage for
7 immunizations of a child from birth to five years of age as provided by
8 department of health and senior services regulations.

9 2. Such coverage shall not be subject to any deductible or co-payment
10 limits.

11 3. The contract issued by a health maintenance organization may provide
12 that the benefits required pursuant to this section shall be covered benefits only
13 if the services are rendered by a provider who is designated by and affiliated with
14 the health maintenance organization, except that the health maintenance
15 organization shall, as a condition of participation, comply with the immunization
16 requirements of state or federally funded health programs.

17 4. This section shall not apply to supplemental insurance policies,
18 including life care contracts, accident-only policies, specified disease policies,
19 hospital policies providing a fixed daily benefit only, Medicare supplement
20 policies, long-term care policies, coverage issued as a supplement to liability
21 insurance, short-term major medical policies [of six months or less duration]
22 **having a duration of less than one year**, and other supplemental policies as
23 determined by the department of commerce and insurance.

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

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

376.1218. 1. Any health carrier or health benefit plan that offers or
2 issues health benefit plans, other than Medicaid health benefit plans, which are
3 delivered, issued for delivery, continued, or renewed in this state on or after
4 January 1, 2006, shall provide coverage for early intervention services described
5 in this section that are delivered by early intervention specialists who are health

6 care professionals licensed by the state of Missouri and acting within the scope
7 of their professions for children from birth to age three identified by the Part C
8 early intervention system as eligible for services under Part C of the Individuals
9 with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Such coverage
10 shall be limited to three thousand dollars for each covered child per policy per
11 calendar year, with a maximum of nine thousand dollars per child.

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

14 3. In the event that any health benefit plan is found not to be required to
15 provide coverage under subsection 1 of this section because of preemption by a
16 federal law, including but not limited to the act commonly known as ERISA
17 contained in Title 29 of the United States Code, or in the event that subsection
18 1 of this section is found to be unconstitutional, then the lead agency shall be
19 responsible for payment and provision of any benefit provided under this section.

20 4. For purposes of this section, "early intervention services" means
21 medically necessary speech and language therapy, occupational therapy, physical
22 therapy, and assistive technology devices for children from birth to age three who
23 are identified by the Part C early intervention system as eligible for services
24 under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section
25 1431, et seq. Early intervention services shall include services under an active
26 individualized family service plan that enhance functional ability without
27 effecting a cure. An individualized family service plan is a written plan for
28 providing early intervention services to an eligible child and the child's family
29 that is adopted in accordance with 20 U.S.C. Section 1436. The Part C early
30 intervention system, on behalf of its contracted regional Part C early intervention
31 system centers and providers, shall be considered the rendering provider of
32 services for purposes of this section.

33 5. No payment made for specified early intervention services shall be
34 applied by the health carrier or health benefit plan against any maximum
35 lifetime aggregate specified in the policy or health benefit plan if the carrier opts
36 to satisfy its obligations under this section under subdivision (2) of subsection 7
37 of this section. A health benefit plan shall be billed at the applicable Medicaid
38 rate at the time the covered benefit is delivered, and the health benefit plan shall
39 pay the Part C early intervention system at such rate for benefits covered by this
40 section. Services under the Part C early intervention system shall be delivered
41 as prescribed by the individualized family service plan and an electronic claim

42 filed in accordance with the carrier's or plan's standard format. Beginning
43 January 1, 2007, such claims' payments shall be made in accordance with the
44 provisions of sections 376.383 and 376.384.

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

48 7. (1) Subject to the provisions of this section, payments made during a
49 calendar year by a health carrier or group of carriers affiliated by or under
50 common ownership or control to the Part C early intervention system for services
51 provided to children covered by the Part C early intervention system shall not
52 exceed one-half of one percent of the direct written premium for health benefit
53 plans as reported to the department of commerce and insurance on the health
54 carrier's most recently filed annual financial statement.

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

68 8. This section shall not apply to a supplemental insurance policy,
69 including a life care contract, specified disease policy, hospital policy providing
70 a fixed daily benefit only, Medicare supplement policy, hospitalization-surgical
71 care policy, policy that is individually underwritten or provides such coverage for
72 specific individuals and members of their families, long-term care policy, or
73 short-term major medical policies [of six months or less duration] **having a**
74 **duration of less than one year.**

75 9. Except for health carriers or health benefit plans making payments
76 under subdivision (2) of subsection 7 of this section, the department of commerce
77 and insurance shall collect data related to the number of children receiving

78 private insurance coverage under this section and the total amount of moneys
79 paid on behalf of such children by private health carriers or health benefit
80 plans. The department shall report to the general assembly regarding the
81 department's findings no later than January 30, 2007, and annually thereafter.

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

376.1219. 1. Each policy issued by an entity offering individual and group
2 health insurance which provides coverage on an expense-incurred basis,
3 individual and group health service or indemnity type contracts issued by a
4 nonprofit corporation, individual and group service contracts issued by a health
5 maintenance organization, all self-insured group health arrangements to the
6 extent not preempted by federal law, and all health care plans provided by
7 managed health care delivery entities of any type or description, that are
8 delivered, issued for delivery, continued or renewed in this state on or after
9 September 1, 1997, shall provide coverage for formula and low protein modified
10 food products recommended by a physician for the treatment of a patient with
11 phenylketonuria or any inherited disease of amino and organic acids who is
12 covered under the policy, contract, or plan and who is less than six years of age.

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

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

26 4. This section shall not apply to a supplemental insurance policy,
27 including a life care contract, accident-only policy, specified disease policy,
28 hospital policy providing a fixed daily benefit only, Medicare supplement policy,
29 long-term care policy, **short-term major medical policy having a duration**
30 **of less than one year**, or any other supplemental policy as determined by the

31 director of the department of commerce and insurance.

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

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

14 3. This section shall not apply to a supplemental insurance policy,
15 including a life care contract, accident-only policy, specified disease policy,
16 hospital policy providing a fixed daily benefit only, Medicare supplement policy,
17 long-term care policy, short-term major medical policies [of six months or less
18 duration] **having a duration of less than one year**, or any other
19 supplemental policy as determined by the director of the department of commerce
20 and insurance.

21 4. Coverage for newborn hearing screening and any necessary rescreening
22 and audiological assessment shall be provided to newborns eligible for medical
23 assistance pursuant to section 208.151, and the children's health program
24 pursuant to sections 208.631 to 208.660, with payment for the newborn hearing
25 screening required in section 191.925, and any necessary rescreening, audiological
26 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:

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

7 (2) "Autism service provider":

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

10 Missouri; or

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

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

20 (4) "Developmental or physical disability", a severe chronic disability that:

21 (a) Is attributable to cerebral palsy, epilepsy, or any other condition other
22 than mental illness or autism spectrum disorder which results in impairment of
23 general intellectual functioning or adaptive behavior and requires treatment or
24 services;

25 (b) Manifests before the individual reaches age nineteen;

26 (c) Is likely to continue indefinitely; and

27 (d) Results in substantial functional limitations in three or more of the
28 following areas of major life activities:

29 a. Self-care;

30 b. Understanding and use of language;

31 c. Learning;

32 d. Mobility;

33 e. Self-direction; or

34 f. Capacity for independent living;

35 (5) "Diagnosis", medically necessary assessments, evaluations, or tests in
36 order to diagnose whether an individual has an autism spectrum disorder or a
37 developmental or physical disability;

38 (6) "Habilitative or rehabilitative care", professional, counseling, and
39 guidance services and treatment programs, including applied behavior analysis
40 for those diagnosed with autism spectrum disorder, that are necessary to develop
41 the functioning of an individual;

42 (7) "Health benefit plan", shall have the same meaning ascribed to it as
43 in section 376.1350;

44 (8) "Health carrier", shall have the same meaning ascribed to it as in
45 section 376.1350;

46 (9) "Line therapist", an individual who provides supervision of an
47 individual diagnosed with an autism diagnosis and other neurodevelopmental
48 disorders pursuant to the prescribed treatment plan, and implements specific
49 behavioral interventions as outlined in the behavior plan under the direct
50 supervision of a licensed behavior analyst;

51 (10) "Pharmacy care", medications used to address symptoms of an autism
52 spectrum disorder or a developmental or physical disability prescribed by a
53 licensed physician, and any health-related services deemed medically necessary
54 to determine the need or effectiveness of the medications only to the extent that
55 such medications are included in the insured's health benefit plan;

56 (11) "Psychiatric care", direct or consultative services provided by a
57 psychiatrist licensed in the state in which the psychiatrist practices;

58 (12) "Psychological care", direct or consultative services provided by a
59 psychologist licensed in the state in which the psychologist practices;

60 (13) "Therapeutic care", services provided by licensed speech therapists,
61 occupational therapists, or physical therapists;

62 (14) "Treatment", care prescribed or ordered for an individual diagnosed
63 with an autism spectrum disorder by a licensed physician or licensed
64 psychologist, or for an individual diagnosed with a developmental or physical
65 disability by a licensed physician or licensed psychologist, including equipment
66 medically necessary for such care, pursuant to the powers granted under such
67 licensed physician's or licensed psychologist's license, including, but not limited
68 to:

69 (a) Psychiatric care;

70 (b) Psychological care;

71 (c) Habilitative or rehabilitative care, including applied behavior analysis
72 therapy for those diagnosed with autism spectrum disorder;

73 (d) Therapeutic care;

74 (e) Pharmacy care.

75 2. Except as otherwise provided in subsection 12 of this section, all health
76 benefit plans that are delivered, issued for delivery, continued, or renewed on or
77 after January 1, 2020, if written inside the state of Missouri, or written outside
78 the state of Missouri but insuring Missouri residents, shall provide coverage for
79 the diagnosis and treatment of autism spectrum disorders and for the diagnosis
80 and treatment of developmental or physical disabilities to the extent that such
81 diagnosis and treatment is not already covered by the health benefit plan.

82 3. With regards to a health benefit plan, a health carrier shall not deny
83 or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse
84 to reissue or otherwise terminate or restrict coverage on an individual or their
85 dependent because the individual is diagnosed with autism spectrum disorder or
86 developmental or physical disabilities.

87 4. (1) Coverage provided under this section for autism spectrum disorder
88 or developmental or physical disabilities is limited to medically necessary
89 treatment that is ordered by the insured's treating licensed physician or licensed
90 psychologist, pursuant to the powers granted under such licensed physician's or
91 licensed psychologist's license, in accordance with a treatment plan.

92 (2) The treatment plan, upon request by the health benefit plan or health
93 carrier, shall include all elements necessary for the health benefit plan or health
94 carrier to pay claims. Such elements include, but are not limited to, a diagnosis,
95 proposed treatment by type, frequency and duration of treatment, and goals.

96 (3) Except for inpatient services, if an individual is receiving treatment
97 for an autism spectrum disorder or developmental or physical disability, a health
98 carrier shall have the right to review the treatment plan not more than once
99 every six months unless the health carrier and the individual's treating physician
100 or psychologist agree that a more frequent review is necessary. Any such
101 agreement regarding the right to review a treatment plan more frequently shall
102 only apply to a particular individual receiving applied behavior analysis and shall
103 not apply to all individuals receiving applied behavior analysis from that autism
104 service provider, physician, or psychologist. The cost of obtaining any review or
105 treatment plan shall be borne by the health benefit plan or health carrier, as
106 applicable.

107 5. (1) Coverage provided under this section for applied behavior analysis
108 shall be subject to a maximum benefit of forty thousand dollars per calendar year
109 for individuals through eighteen years of age. Such maximum benefit limit may
110 be exceeded, upon prior approval by the health benefit plan, if the provision of
111 applied behavior analysis services beyond the maximum limit is medically
112 necessary for such individual. Payments made by a health carrier on behalf of
113 a covered individual for any care, treatment, intervention, service or item, the
114 provision of which was for the treatment of a health condition unrelated to the
115 covered individual's autism spectrum disorder, shall not be applied toward any
116 maximum benefit established under this subsection. Any coverage required
117 under this section, other than the coverage for applied behavior analysis, shall

118 not be subject to the age and dollar limitations described in this subsection.

119 (2) The maximum benefit limitation for applied behavior analysis
120 described in subdivision (1) of this subsection shall be adjusted by the health
121 carrier at least triennially for inflation to reflect the aggregate increase in the
122 general price level as measured by the Consumer Price Index for All Urban
123 Consumers for the United States, or its successor index, as defined and officially
124 published by the United States Department of Labor, or its successor
125 agency. Beginning January 1, 2012, and annually thereafter, the current value
126 of the maximum benefit limitation for applied behavior analysis coverage
127 adjusted for inflation in accordance with this subsection shall be calculated by the
128 director of the department of commerce and insurance. The director shall furnish
129 the calculated value to the secretary of state, who shall publish such value in the
130 Missouri Register as soon after each January first as practicable, but it shall
131 otherwise be exempt from the provisions of section 536.021.

132 (3) Subject to the provisions set forth in subdivision (3) of subsection 4 of
133 this section, coverage provided for autism spectrum disorders under this section
134 shall not be subject to any limits on the number of visits an individual may make
135 to an autism service provider, except that the maximum total benefit for applied
136 behavior analysis set forth in subdivision (1) of this subsection shall apply to this
137 subdivision.

138 6. Coverage for therapeutic care provided under this section for
139 developmental or physical disabilities may be limited to a number of visits per
140 calendar year, provided that upon prior approval by the health benefit plan,
141 coverage shall be provided beyond the maximum calendar limit if such
142 therapeutic care is medically necessary as determined by the health care plan.

143 7. This section shall not be construed as limiting benefits which are
144 otherwise available to an individual under a health benefit plan. The health care
145 coverage required by this section shall not be subject to any greater deductible,
146 coinsurance, or co-payment than other physical health care services provided by
147 a health benefit plan. Coverage of services may be subject to other general
148 exclusions and limitations of the contract or benefit plan, not in conflict with the
149 provisions of this section, such as coordination of benefits, exclusions for services
150 provided by family or household members, and utilization review of health care
151 services, including review of medical necessity and care management; however,
152 coverage for treatment under this section shall not be denied on the basis that it
153 is educational or habilitative in nature.

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

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

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

161 Such payments or reimbursements under this subsection to an autism service
162 provider or a board-certified behavior analyst shall include payments or
163 reimbursements for services provided by a line therapist under the supervision
164 of such provider or behavior analyst if such services provided by the line
165 therapist are included in the treatment plan and are deemed medically necessary.

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

169 10. The provisions of this section shall apply to any health care plans
170 issued to employees and their dependents under the Missouri consolidated health
171 care plan established pursuant to chapter 103 that are delivered, issued for
172 delivery, continued, or renewed in this state on or after January 1, 2020. The
173 terms "employees" and "health care plans" shall have the same meaning ascribed
174 to them in section 103.003.

175 11. The provisions of this section shall also apply to the following types
176 of plans that are established, extended, modified, or renewed on or after January
177 1, 2020:

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

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

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

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

187 12. The provisions of this section shall not apply to a supplemental
188 insurance policy, including a life care contract, accident-only policy, specified
189 disease policy, hospital policy providing a fixed daily benefit only, Medicare

190 supplement policy, long-term care policy, short-term major medical policy [of six
191 months or less duration] **having a duration of less than one year**, or any
192 other supplemental policy. The provisions of this section requiring coverage for
193 autism spectrum disorders shall not apply to an individually underwritten health
194 benefit plan issued prior to January 1, 2011. The provisions of this section
195 requiring coverage for a developmental or physical disability shall not apply to
196 a health benefit plan issued prior to January 1, 2014.

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

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

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

376.1225. 1. All individual and group health insurance policies providing
2 coverage on an expense-incurred basis, individual and group service or indemnity
3 type contracts issued by a nonprofit corporation, individual and group service
4 contracts issued by a health maintenance organization, all self-insured group
5 arrangements to the extent not preempted by federal law and all managed health
6 care delivery entities of any type or description, that are delivered, issued for
7 delivery, continued or renewed on or after August 28, 1998, shall provide coverage
8 for administration of general anesthesia and hospital charges for dental care
9 provided to the following covered persons:

- 10 (1) A child under the age of five;
- 11 (2) A person who is severely disabled; or
- 12 (3) A person who has a medical or behavioral condition which requires
13 hospitalization or general anesthesia when dental care is provided.

14 2. Each plan as described in this section must provide coverage for

15 administration of general anesthesia and hospital or office charges for treatment
16 rendered by a dentist, regardless of whether the services are provided in a
17 participating hospital or surgical center or office.

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

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

376.1230. 1. Every policy issued by a health carrier, as defined in section
2 376.1350, shall provide coverage for chiropractic care delivered by a licensed
3 chiropractor acting within the scope of his or her practice as defined in chapter
4 331. The coverage shall include initial diagnosis and clinically appropriate and
5 medically necessary services and supplies required to treat the diagnosed
6 disorder, subject to the terms and conditions of the policy. The coverage may be
7 limited to chiropractors within the health carrier's network, and nothing in this
8 section shall be construed to require a health carrier to contract with a
9 chiropractor not in the carrier's network nor shall a carrier be required to
10 reimburse for services rendered by a nonnetwork chiropractor unless prior
11 approval has been obtained from the carrier by the enrollee. An enrollee may
12 access chiropractic care within the network for a total of twenty-six chiropractic
13 physician office visits per policy period, but may be required to provide the health
14 carrier with notice prior to any additional visit as a condition of coverage. A
15 health carrier may require prior authorization or notification before any follow-up
16 diagnostic tests are ordered by a chiropractor or for any office visits for treatment
17 in excess of twenty-six in any policy period. The certificate of coverage for any
18 health benefit plan issued by a health carrier shall clearly state the availability
19 of chiropractic coverage under the policy and any limitations, conditions, and
20 exclusions.

21 2. A health benefit plan shall provide coverage for treatment of a
22 chiropractic care condition and shall not establish any rate, term, or condition
23 that places a greater financial burden on an insured for access to treatment for
24 a chiropractic care condition than for access to treatment for another physical
25 health condition.

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

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

30 5. The provisions of this section shall not apply to a supplemental
31 insurance policy, including a life care contract, accident-only policy, specified
32 disease policy, hospital policy providing a fixed daily benefit only, Medicare
33 supplement policy, long-term care policy, short-term major medical policy [of six
34 months' or less duration] **having a duration of less than one year**, or any
35 other similar supplemental policy.

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

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

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

18 4. The provisions of this section shall not apply to a supplemental
19 insurance policy, including a life care contract, accident-only policy, specified
20 disease policy, hospital policy providing a fixed daily benefit only, Medicare
21 supplement policy, long-term care policy, short-term major medical policies [of six
22 months or less duration] **having a duration of less than one year**, or any
23 other supplemental policy as determined by the director of the department of
24 commerce and insurance.

376.1235. 1. No health carrier or health benefit plan, as defined in
2 section 376.1350, shall impose a co-payment or coinsurance percentage charged

3 to the insured for services rendered for each date of service by a physical
4 therapist licensed under chapter 334 or an occupational therapist licensed under
5 chapter 324, for services that require a prescription, that is greater than the
6 co-payment or coinsurance percentage charged to the insured for the services of
7 a primary care physician licensed under chapter 334 for an office visit.

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

11 3. Beginning September 1, 2016, the oversight division of the joint
12 committee on legislative research shall perform an actuarial analysis of the cost
13 impact to health carriers, insureds with a health benefit plan, and other private
14 and public payers if the provisions of this section regarding occupational therapy
15 coverage were enacted. By December 31, 2016, the director of the oversight
16 division of the joint committee on legislative research shall submit a report of the
17 actuarial findings prescribed by this section to the speaker, the president pro tem,
18 and the chairpersons of both the house of representatives and senate standing
19 committees having jurisdiction over health insurance matters. If the fiscal note
20 cost estimation is less than the cost of an actuarial analysis, the actuarial
21 analysis requirement shall be waived.

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

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

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

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

14 4. The provisions of this section shall not apply to a supplemental
15 insurance policy, including a life care contract, accident-only policy, specified

16 disease policy, hospital policy providing a fixed daily benefit only, Medicare
17 supplement policy, long-term care policy, short-term major medical policies [of six
18 months' or less duration] **having a duration of less than one year**, or any
19 other supplemental policy as determined by the director of the department of
20 commerce and insurance.

376.1250. 1. All individual and group health insurance policies providing
2 coverage on an expense-incurred basis, individual and group service or indemnity
3 type contracts issued by a nonprofit corporation, individual and group service
4 contracts issued by a health maintenance organization, all self-insured group
5 arrangements to the extent not preempted by federal law and all managed health
6 care delivery entities of any type or description, that are delivered, issued for
7 delivery, continued or renewed on or after August 28, 1999, and providing
8 coverage to any resident of this state shall provide benefits or coverage for:

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

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

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

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

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

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

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

30 6. Nothing in this section shall alter, impair or otherwise affect claims,
31 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 commerce and insurance.

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

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

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

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

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

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

40 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
2 issues health benefit plans which are delivered, issued for delivery, continued, or
3 renewed in this state on or after January 1, 2003, shall include coverage for their
4 members for the cost for human leukocyte antigen testing, also referred to as
5 histocompatibility locus antigen testing, for A, B, and DR antigens for utilization
6 in bone marrow transplantation. The testing must be performed in a facility
7 which is accredited by the American Association of Blood Banks or its successors,
8 and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section
9 263a, as amended, and is accredited by the American Association of Blood Banks

10 or its successors, the College of American Pathologists, the American Society for
11 Histocompatibility and Immunogenetics (ASHI) or any other national accrediting
12 body with requirements that are substantially equivalent to or more stringent
13 than those of the College of American Pathologists. At the time of testing, the
14 person being tested must complete and sign an informed consent form which also
15 authorizes the results of the test to be used for participation in the National
16 Marrow Donor Program. The health benefit plan may limit each enrollee to one
17 such testing per lifetime to be reimbursed at a cost of no greater than seventy-five
18 dollars by the health carrier or health benefit plan.

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

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

24 4. The provisions of this section shall not apply to a supplemental
25 insurance policy, including a life care contract, accident-only policy, specified
26 disease policy, hospital policy providing a fixed daily benefit only, Medicare
27 supplement policy, long-term care policy, short-term major medical policies [of six
28 months' or less duration] **having a duration of less than one year**, or any
29 other supplemental policy as determined by the director of the department of
30 commerce and insurance.

376.1290. 1. Each entity offering individual and group health insurance
2 policies providing coverage on an expense-incurred basis, individual and group
3 service or indemnity type contracts issued by a health services corporation,
4 individual and group service contracts issued by a health maintenance
5 organization, all self-insured group arrangements, to the extent not preempted
6 by federal law, and all managed health care delivery entities of any type or
7 description that are delivered, issued for delivery, continued or renewed in this
8 state on or after January 1, 2002, shall offer coverage for testing pregnant women
9 for lead poisoning and for all testing for lead poisoning authorized by sections
10 701.340 to 701.349 or by rule of the department of health and senior services
11 promulgated pursuant to sections 701.340 to 701.349.

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

15 3. No entity enumerated in subsection 1 of this section shall reduce or

16 eliminate coverage as a result of the requirements of this section.

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

376.1400. 1. Every health insurance carrier offering policies of insurance
2 in this state shall use standardized information for the explanation of benefits
3 given to the health care provider whenever a claim is paid or denied. As used in
4 this section, the term "health insurance carrier" shall have the meaning given to
5 "health carrier" in section 376.1350. Nothing in this section shall apply to
6 accident-only, specified disease, hospital indemnity, Medicare supplement,
7 long-term care, short-term major medical policies [of six months or less duration]
8 **having a duration of less than one year**, other limited benefit health
9 insurance policies.

10 2. The standardized information shall contain the following:

- 11 (1) The name of the insured;
- 12 (2) The insured's identification number;
- 13 (3) The date of service;
- 14 (4) Amount of charge;
- 15 (5) Explanation for any denial;
- 16 (6) The amount paid;
- 17 (7) The patient's full name;
- 18 (8) The name and address of the insurer; and
- 19 (9) The phone number to contact for questions on explanation of benefits.

20 3. All health insurance carriers shall use the standard explanation of
21 benefits information after January 1, 2002.

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

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

11 plan shall be comprehensive for coverage of all health conditions, whether mental
12 or physical;

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

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

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

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

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

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

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

34 (4) Coverage for treatment for chemical dependency shall comply with
35 sections 376.779, 376.810 to 376.814, and 376.825 to 376.836 and for the purposes
36 of this subdivision the term "health insurance policy" as used in sections 376.779,
37 376.810 to 376.814, and 376.825 to 376.836[, the term "health insurance policy"]
38 shall include group coverage.

39 2. As used in this section, the following terms mean:

40 (1) "Chemical dependency", the psychological or physiological dependence
41 upon and abuse of drugs, including alcohol, characterized by drug tolerance or
42 withdrawal and impairment of social or occupational role functioning or both;

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

45 (3) "Health carrier", the same meaning as such term is defined in section
46 376.1350;

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

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

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

58 3. This section shall not apply to a health plan or policy that is
59 individually underwritten or provides such coverage for specific individuals and
60 members of their families pursuant to section 376.779, sections 376.810 to
61 376.814, and sections 376.825 to 376.836, a supplemental insurance policy,
62 including a life care contract, accident-only policy, specified disease policy,
63 hospital policy providing a fixed daily benefit only, Medicare supplement policy,
64 long-term care policy, hospitalization-surgical care policy, short-term major
65 medical policies [of six months or less duration] **having a duration of less**
66 **than one year**, or any other supplemental policy as determined by the director
67 of the department of commerce and insurance.

68 4. Notwithstanding any other provision of law to the contrary, all health
69 insurance policies that cover state employees, including the Missouri consolidated
70 health care plan, shall include coverage for mental illness. Multiyear group
71 policies need not comply until the expiration of their current multiyear term
72 unless the policyholder elects to comply before that time.

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

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

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

78 (3) Care that is custodial in nature;

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

81 (5) Treatments that are considered experimental.

82 6. The director shall grant a policyholder a waiver from the provisions of

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

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

- 2 (1) "Electronic visit", or "e-visit", an online electronic medical evaluation
3 and management service completed using a secured web-based or similar
4 electronic-based communications network for a single patient encounter. An
5 electronic visit shall be initiated by a patient or by the guardian of a patient with
6 the health care provider, be completed using a federal Health Insurance
7 Portability and Accountability Act (HIPAA)-compliant online connection, and
8 include a permanent record of the electronic visit;
- 9 (2) "Health benefit plan" shall have the same meaning ascribed to it in
10 section 376.1350;
- 11 (3) "Health care provider" shall have the same meaning ascribed to it in
12 section 376.1350;
- 13 (4) "Health care service", a service for the diagnosis, prevention,
14 treatment, cure or relief of a physical or mental health condition, illness, injury
15 or disease;
- 16 (5) "Health carrier" shall have the same meaning ascribed to it in section
17 376.1350;
- 18 (6) "Telehealth" shall have the same meaning ascribed to it in section
19 208.670.

20 2. Each health carrier or health benefit plan that offers or issues health
21 benefit plans which are delivered, issued for delivery, continued, or renewed in
22 this state on or after January 1, 2014, shall not deny coverage for a health care

23 service on the basis that the health care service is provided through telehealth
24 if the same service would be covered if provided through face-to-face diagnosis,
25 consultation, or treatment.

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

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

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

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

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

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

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

58 10. The provisions of this section shall not apply to a supplemental

59 insurance policy, including a life care contract, accident-only policy, specified
60 disease policy, hospital policy providing a fixed daily benefit only, Medicare
61 supplement policy, long-term care policy, short-term major medical policies [of six
62 months' or less duration] **having a duration of less than one year**, or any
63 other supplemental policy as determined by the director of the department of
64 commerce and insurance.

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