FIRST REGULAR SESSION

[PERFECTED]

HOUSE BILL NO. 83

100TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE HILL.

0109H.01P DANA RADEMAN MILLER, Chief Clerk

AN ACT

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

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

Section A. 191.671, 376.385, 376.429, 376.446, 376.452, 376.454, 376.690, 376.779,
2 376.781, 376.782, 376.811, 376.845, 376.1199, 376.1200, 376.1209, 376.1210, 376.1215,
3 376.1218, 376.1219, 376.1220, 376.1224, 376.1225, 376.1230, 376.1232, 376.1235, 376.1237,
4 376.1250, 376.1253, 376.1257, 376.1275, 376.1290, 376.1400, 376.1550, and 376.1900, RSMo,
5 are repealed and thirty-five new sections enacted in lieu thereof, to be known as sections
6 191.671, 376.008, 376.385, 376.429, 376.446, 376.452, 376.454, 376.690, 376.779, 376.781,
7 376.782, 376.811, 376.845, 376.1199, 376.1200, 376.1209, 376.1210, 376.1215, 376.1218,
8 376.1219, 376.1220, 376.1224, 376.1225, 376.1230, 376.1232, 376.1235, 376.1237, 376.1250,
9 376.1253, 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
2 corporation, or health maintenance organization licensed by the department of insurance,
3 financial institutions and professional registration which conducts HIV testing only for the
4 purposes of assessing a person's fitness for insurance coverage offered by such insurer, health

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

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

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

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

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

28 5. The result or results of HIV testing of an applicant for insurance coverage shall not
29 be disclosed by an insurer, health services corporation or health maintenance organization,
30 except as specifically authorized by such applicant in writing. Such result or results shall,
31 however, be disclosed to a physician designated by the subject of the test. If there is no physician
32 designated, the insurer, health services corporation, or health maintenance organization shall
33 disclose the identity of individuals residing in Missouri having a confirmed positive HIV test
34 result to the department of health and senior services. Provided, further, that no such insurer,
35 health services corporation or health maintenance organization shall be liable for violating any
36 duty or right of confidentiality established by law for disclosing such identity of individuals
37 having a confirmed positive HIV test result to the department of health and senior services. Such
38 disclosure shall be in a manner that ensures confidentiality. Disclosure of test results in violation
39 of this section shall constitute a violation of sections 375.930 to 375.948 regulating trade

40 practices in the business of insurance. Nothing in this subsection shall be construed to foreclose
41 any remedies existing on June 1, 1988.

376.008. 1. All short-term major medical policies delivered or issued for delivery
2 **in this state shall include on any application for coverage and on the fact page of all policies**
3 **a conspicuous and clearly captioned paragraph stating:**
4
5 **This policy may not cover preexisting conditions, including conditions you may currently**
6 **have and are unaware of but are not diagnosed until the policy's term. This policy may not**
7 **cover certain essential health benefits, including prescription drugs, preventative care, and**
8 **emergency services. Before you realize benefits under this policy, you may be responsible**
9 **for a deductible and/or coinsurance. Be sure to discuss these items with your insurance**
10 **broker before purchasing a short-term medical policy.**
11 **2. No short-term major medical policy shall be delivered or issued for delivery in**
12 **this state until the prospective insured has confirmed receipt of a benefit summary**
13 **statement. As used in this section, "benefit summary statement" shall mean a no more**
14 **than two-page plain language explanation of the following:**
15 **(1) Coverage limits, if any, expressed in dollars for:**
16 **(a) Each occurrence;**
17 **(b) Each covered benefit including, but not limited to, any benefit that is or was a**
18 **covered benefit for any duration or dollar amount during the contract period and anything**
19 **included under subdivision (2) of this subsection; and**
20 **(c) Each contract period;**
21 **(2) Co-payments and deductibles for each covered benefit including, but not limited**
22 **to:**
23 **(a) Inpatient hospital care;**
24 **(b) Outpatient hospital care;**
25 **(c) Nonhospital inpatient care;**
26 **(d) Nonhospital outpatient care;**
27 **(e) Prescription drugs; and**
28 **(f) Emergency services; and**
29 **(3) Any co-payment or deductible for an illness or affliction which differs from the**
30 **co-payment or deductible required to be described under subdivision (2) of this subsection.**

376.385. 1. Each entity offering individual and group health insurance policies
2 providing coverage on an expense-incurred basis, individual and group service or indemnity type
3 contracts issued by a health services corporation, individual and group service contracts issued
4 by a health maintenance organization, all self-insured group arrangements, to the extent not

5 preempted by federal law, and all managed health care delivery entities of any type or
6 description, that are delivered, issued for delivery, continued or renewed in this state on or after
7 January 1, 1998, shall offer coverage for all physician-prescribed medically appropriate and
8 necessary equipment, supplies and self-management training used in the management and
9 treatment of diabetes. Coverage shall include persons with gestational, type I or type II diabetes.
10 2. Health care services required by this section shall not be subject to any greater
11 deductible or co-payment than any other health care service provided by the policy, contract or
12 plan.
13 3. No entity enumerated in subsection 1 of this section may reduce or eliminate coverage
14 due to the requirements of this section.
15 4. Nothing in this section shall apply to accident-only, specified disease, hospital
16 indemnity, Medicare supplement, long-term care, **short-term major medical policies having**
17 **a duration of less than one year,** or other limited benefit health insurance policies.

376.429. 1. All health benefit plans, as defined in section 376.1350, that are delivered,
2 issued for delivery, continued or renewed on or after August 28, 2006, and providing coverage
3 to any resident of this state shall provide coverage for routine patient care costs as defined in
4 subsection 7 of this section incurred as the result of phase II, III, or IV of a clinical trial that is
5 approved by an entity listed in subsection 4 of this section and is undertaken for the purposes of
6 the prevention, early detection, or treatment of cancer. Health benefit plans may limit coverage
7 for the routine patient care costs of patients in phase II of a clinical trial to those treating facilities
8 within the health benefit plans' provider network; except that, this provision shall not be
9 construed as relieving a health benefit plan of the sufficiency of network requirements under
10 state statute.
11 2. In the case of treatment under a clinical trial, the treating facility and personnel must
12 have the expertise and training to provide the treatment and treat a sufficient volume of patients.
13 There must be equal to or superior, noninvestigational treatment alternatives and the available
14 clinical or preclinical data must provide a reasonable expectation that the treatment will be
15 superior to the noninvestigational alternatives.
16 3. Coverage required by this section shall include coverage for routine patient care costs
17 incurred for drugs and devices that have been approved for sale by the Food and Drug
18 Administration (FDA), regardless of whether approved by the FDA for use in treating the
19 patient's particular condition, including coverage for reasonable and medically necessary services
20 needed to administer the drug or use the device under evaluation in the clinical trial.
21 4. Subsections 1 and 2 of this section requiring coverage for routine patient care costs
22 shall apply to phase III or IV of clinical trials that are approved or funded by one of the following
23 entities:

24 (1) One of the National Institutes of Health (NIH);
25 (2) An NIH cooperative group or center as defined in subsection 7 of this section;
26 (3) The FDA in the form of an investigational new drug application;
27 (4) The federal Departments of Veterans' Affairs or Defense;
28 (5) An institutional review board in this state that has an appropriate assurance approved
29 by the Department of Health and Human Services assuring compliance with and implementation
30 of regulations for the protection of human subjects (45 CFR 46); or
31 (6) A qualified research entity that meets the criteria for NIH Center support grant
32 eligibility.
33 5. Subsections 1 and 2 of this section requiring coverage for routine patient care costs
34 shall apply to phase II of clinical trials if:
35 (1) Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or
36 National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center;
37 and
38 (2) The person covered under this section is enrolled in the clinical trial. This section
39 shall not apply to persons who are only following the protocol of phase II of a clinical trial, but
40 not actually enrolled.
41 6. An entity seeking coverage for treatment, prevention, or early detection in a clinical
42 trial approved by an institutional review board under subdivision (5) of subsection 4 of this
43 section shall maintain and post electronically a list of the clinical trials meeting the requirements
44 of subsections 2 and 3 of this section. This list shall include: the phase for which the clinical
45 trial is approved; the entity approving the trial; the particular disease; and the number of
46 participants in the trial. If the electronic posting is not practical, the entity seeking coverage shall
47 periodically provide payers and providers in the state with a written list of trials providing the
48 information required in this section.
49 7. As used in this section, the following terms shall mean:
50 (1) "Cooperative group", a formal network of facilities that collaborate on research
51 projects and have an established NIH-approved Peer Review Program operating within the
52 group, including the NCI Clinical Cooperative Group and the NCI Community Clinical
53 Oncology Program;
54 (2) "Multiple project assurance contract", a contract between an institution and the
55 federal Department of Health and Human Services (DHHS) that defines the relationship of the
56 institution to the DHHS and sets out the responsibilities of the institution and the procedures that
57 will be used by the institution to protect human subjects;
58 (3) "Routine patient care costs" shall include coverage for reasonable and medically
59 necessary services needed to administer the drug or device under evaluation in the clinical trial.

60 Routine patient care costs include all items and services that are otherwise generally available
61 to a qualified individual that are provided in the clinical trial except:
62 (a) The investigational item or service itself;
63 (b) Items and services provided solely to satisfy data collection and analysis needs and
64 that are not used in the direct clinical management of the patient; and
65 (c) Items and services customarily provided by the research sponsors free of charge for
66 any enrollee in the trial.
67 8. For the purpose of this section, providers participating in clinical trials shall obtain
68 a patient's informed consent for participation on the clinical trial in a manner that is consistent
69 with current legal and ethical standards. Such documents shall be made available to the health
70 insurer upon request.
71 9. The provisions of this section shall not apply to a policy, plan or contract paid under
72 Title XVIII or Title XIX of the Social Security Act.
73 10. Nothing in this section shall apply to any accident-only policy, specified disease
74 policy, hospital indemnity policy, Medicare supplement policy, long-term care policy, short-term
75 major medical policy **[**~~of six months or less duration~~**] having a duration of less than one year**,
76 or other limited benefit health insurance policies.
77 11. The provisions of this section regarding phase II of a clinical trial shall not apply
78 automatically to an individually underwritten health benefit plan, but shall be an option to any
79 such plan.

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

16 [2.] **3.** This section shall not apply to a supplemental insurance policy, including a life
17 care contract, accident-only policy, specified disease policy, hospital policy providing a fixed
18 daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical
19 care policy**[**~~, short-term major medical policy of six months or less duration~~**]**, or any other
20 supplemental policy.

21 **[**~~3.~~**] 4.** The provisions of subsections 1 and 2 shall become effective on January 1, 2014.

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

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

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

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

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

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

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

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

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

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

29 (1) The issuer provides notice to each plan sponsor, participant and beneficiary provided
30 coverage of this type in the large group market of the discontinuation at least ninety days prior
31 to the date of the discontinuation of the coverage;
32 (2) The issuer offers to each plan sponsor being provided coverage of this type in the
33 large group market the option to purchase any other health insurance coverage currently being
34 offered by the health insurance issuer to a group health plan in the large group market; and
35 (3) The issuer acts uniformly without regard to the claims experience of those plan
36 sponsors or any health status-related factor of any participant or beneficiary covered or new
37 participant or beneficiary who may become eligible for such coverage.
38 4. (1) A health insurance issuer shall not discontinue offering all health insurance
39 coverage in the large group market unless:
40 (a) The issuer provides notice of discontinuation to the director and to each plan sponsor,
41 participant and beneficiary covered at least one hundred eighty days prior to the date of the
42 discontinuation of coverage; and
43 (b) All health insurance issued or delivered for issuance in Missouri in the large group
44 market is discontinued and coverage under such health insurance is not renewed.
45 (2) In the case of a discontinuation under this subsection, the health insurance issuer
46 shall not provide for the issuance of any health insurance coverage in the large group market for
47 a period of five years beginning on the date of the discontinuation of the last health insurance
48 coverage not renewed.
49 5. At the time of coverage renewal, a health insurance issuer may modify the health
50 insurance coverage for a product offered to a group health plan in the large group market. For
51 purposes of this subsection, renewal shall be deemed to occur not more often than annually on
52 the anniversary of the effective date of the group health plan's health insurance coverage unless
53 a longer term is specified in the policy or contract.
54 6. In the case of health insurance coverage that is made available by a health insurance
55 issuer only through one or more bona fide associations, a reference to plan sponsor in this section
56 is deemed, with respect to coverage provided to an employer member of the association, to
57 include a reference to such employer.

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

7 (1) The individual has failed to pay premiums or contributions in accordance with the
8 terms of the health insurance coverage or the issuer has not received timely premium payments;
9 (2) The individual has performed an act or practice that constitutes fraud or made an
10 intentional misrepresentation of material fact under the terms of the coverage;
11 (3) The issuer is ceasing to offer coverage in the individual market in accordance with
12 subsection 4 of this section;
13 (4) In the case of a health insurance issuer that offers health insurance coverage in the
14 market through a network plan, the individual no longer resides, lives, or works in the service
15 area or in an area for which the issuer is authorized to do business but only if such coverage is
16 terminated under this subdivision uniformly without regard to any health status-related factor of
17 covered individuals;
18 (5) In the case of health insurance coverage that is made available in the individual
19 market only through one or more bona fide associations, the membership of the individual in the
20 association on the basis of which the coverage is provided ceases, but only if such coverage is
21 terminated under this subdivision uniformly without regard to any health status-related factor of
22 covered individuals.
23 3. In any case in which an issuer decides to discontinue offering a particular type of
24 health insurance coverage offered in the individual market, coverage of such type may be
25 discontinued by the issuer only if:
26 (1) The issuer provides notice to each covered individual provided coverage of this type
27 in such market of such discontinuation at least ninety days prior to the date of the discontinuation
28 of such coverage;
29 (2) The issuer offers to each individual in the individual market provided coverage of
30 this type, the option to purchase any other individual health insurance coverage currently being
31 offered by the issuer for individuals in such market; and
32 (3) In exercising the option to discontinue coverage of this type and in offering the
33 option of coverage under subdivision (2) of this subsection, the issuer acts uniformly without
34 regard to any health status-related factor of enrolled individuals or individuals who may become
35 eligible for such coverage.
36 4. (1) In any case in which a health insurance issuer elects to discontinue offering all
37 health insurance coverage in the individual market in the state, health insurance coverage may
38 be discontinued by the issuer only if:
39 (a) The issuer provides notice to the director and to each individual of such
40 discontinuation at least one hundred eighty days prior to the date of the expiration of such
41 coverage; and

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

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

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

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

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

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

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

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

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

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

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

2. (1) Health care professionals **[**~~may~~**] shall** send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within one hundred eighty days of the delivery of the unanticipated out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

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

19 commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be
20 the amount from the network which has the highest reimbursement.
21 (3) If the health care professional declines the health carrier's initial offer of
22 reimbursement, the health carrier and health care professional shall have sixty days from the date
23 of the initial offer of reimbursement to negotiate in good faith to attempt to determine the
24 reimbursement for the unanticipated out-of-network care.
25 (4) If the health carrier and health care professional do not agree to a reimbursement
26 amount by the end of the sixty-day negotiation period, the dispute shall be resolved through an
27 arbitration process as specified in subsection 4 of this section.
28 (5) To initiate arbitration proceedings, either the health carrier or health care
29 professional must provide written notification to the director and the other party within one
30 hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the
31 matter and notifying the director of the billed amount and the date and amount of the final offer
32 by each party. A claim for unanticipated out-of-network care may be resolved between the
33 parties at any point prior to the commencement of the arbitration proceedings. Claims may be
34 combined for purposes of arbitration, but only to the extent the claims represent similar
35 circumstances and services provided by the same health care professional, and the parties
36 attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.
37 (6) No health care professional who sends a claim to a health carrier under subsection
38 2 of this section shall send a bill to the patient for any difference between the reimbursement rate
39 as determined under this subsection and the health care professional's billed charge.
40 3. (1) When unanticipated out-of-network care is provided, the health care professional
41 who sends a claim to a health carrier under subsection 2 of this section may bill a patient for no
42 more than the cost-sharing requirements described under this section.
43 (2) Cost-sharing requirements shall be based on the reimbursement amount as
44 determined under subsection 2 of this section.
45 (3) The patient's health carrier shall inform the health care professional of its enrollee's
46 cost-sharing requirements within forty-five processing days of receiving a claim from the health
47 care professional for services provided.
48 (4) The in-network deductible and out-of-pocket maximum cost-sharing requirements
49 shall apply to the claim for the unanticipated out-of-network care.
50 4. The director shall ensure access to an external arbitration process when a health care
51 professional and health carrier cannot agree to a reimbursement under subdivision (3) of
52 subsection 2 of this section. In order to ensure access, when notified of a parties' intent to
53 arbitrate, the director shall randomly select an arbitrator for each case from the department's
54 approved list of arbitrators or entities that provide binding arbitration. The director shall specify

55 the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared
56 equally between and will be directly billed to the health care professional and health carrier.
57 These costs will include, but are not limited to, reasonable time necessary for the arbitrator to
58 review materials in preparation for the arbitration, travel expenses and reasonable time following
59 the arbitration for drafting of the final decision.
60 5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision,
61 which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to
62 the director. The initial request for arbitration, all correspondence and documents received by
63 the department and the final arbitration decision shall be considered a closed record under
64 section 374.071. However, the director may release aggregated summary data regarding the
65 arbitration process. The decision of the arbitrator shall not be considered an agency decision nor
66 shall it be considered a contested case within the meaning of section 536.010.
67 6. The arbitrator shall determine a dollar amount due under subsection 2 of this section
68 between one hundred twenty percent of the Medicare-allowed amount and the seventieth
69 percentile of the usual and customary rate for the unanticipated out-of-network care, as
70 determined by benchmarks from independent nonprofit organizations that are not affiliated with
71 insurance carriers or provider organizations.
72 7. When determining a reasonable reimbursement rate, the arbitrator shall consider the
73 following factors if the health care professional believes the payment offered for the
74 unanticipated out-of-network care does not properly recognize:
75 (1) The health care professional's training, education, or experience;
76 (2) The nature of the service provided;
77 (3) The health care professional's usual charge for comparable services provided;
78 (4) The circumstances and complexity of the particular case, including the time and place
79 the services were provided; and
80 (5) The average contracted rate for comparable services provided in the same geographic
81 area.
82 8. The enrollee shall not be required to participate in the arbitration process. The health
83 care professional and health carrier shall execute a nondisclosure agreement prior to engaging
84 in an arbitration under this section.
85 9. **[**~~This section shall take effect on January 1, 2019.~~
86 ~~10.~~**]** The department of insurance, financial institutions and professional registration may
87 promulgate rules and fees as necessary to implement the provisions of this section, including but
88 not limited to procedural requirements for arbitration. Any rule or portion of a rule, as that term
89 is defined in 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 chapter 536

91 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any
92 of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the
93 effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the
94 grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be
95 invalid and void.

376.779. 1. All health plans or policies that are individually underwritten or provide for
2 such coverage for specific individuals and the members of their families, which provide for
3 hospital treatment, shall provide coverage, while confined in a hospital or in a residential or
4 nonresidential facility certified by the department of mental health, for treatment of alcoholism
5 on the same basis as coverage for any other illness, except that coverage may be limited to thirty
6 days in any policy or contract benefit period. All Missouri individual contracts issued on or after
7 January 1, 2005, shall be subject to this section. Coverage required by this section shall be
8 included in the policy or contract and payment provided as for other coverage in the same policy
9 or contract notwithstanding any construction or relationship of interdependent contracts or plans
10 affecting coverage and payment of reimbursement prerequisites under the policy or contract.
11 2. Insurers, corporations or groups providing coverage may approve for payment or
12 reimbursement vendors and programs providing services or treatment required by this section.
13 Any vendor or person offering services or treatment subject to the provisions of this section and
14 seeking approval for payment or reimbursement shall submit to the department of mental health
15 a detailed description of the services or treatment program to be offered. The department of
16 mental health shall make copies of such descriptions available to insurers, corporations or groups
17 providing coverage under the provisions of this section. Each insurer, corporation or group
18 providing coverage shall notify the vendor or person offering service or treatment as to its
19 acceptance or rejection for payment or reimbursement; provided, however, payment or
20 reimbursement shall be made for any service or treatment program certified by the department
21 of mental health. Any notice of rejection shall contain a detailed statement of the reasons for
22 rejection and the steps and procedures necessary for acceptance. Amended descriptions of
23 services or treatment programs to be offered may be filed with the department of mental health.
24 Any vendor or person rejected for approval of payment or reimbursement may modify their
25 description and treatment program and submit copies of the amended description to the
26 department of mental health and to the insurer, corporation or group which rejected the original
27 description.
28 3. The department of mental health may issue rules necessary to carry out the provisions
29 of this section. No rule or portion of a rule promulgated under the authority of this section shall
30 become effective unless it has been promulgated pursuant to the provisions of section 536.024.

31 4. All substance abuse treatment programs in Missouri receiving funding from the
32 Missouri department of mental health must be certified by the department.
33 5. This section shall not apply to a supplemental insurance policy, including a life care
34 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
35 benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care
36 policy, short-term major medical policy **[**~~of six months or less duration~~**] having a duration of**
37 **less than one year**, or any other supplemental policy as determined by the director of the
38 department of insurance, financial institutions and professional registration.

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 not-for-profit health
3 service corporation, all self-insured group health benefit plans of any type or description, and all
4 such health plans or policies that are individually underwritten or provide for such coverage for
5 specific individuals and the members of their families as nongroup policies, which provide for
6 hospital treatment, shall offer coverage for the necessary care and treatment of loss or
7 impairment of speech or hearing subject to the same durational limits, dollar limits, deductibles
8 and coinsurance factors as other covered services in such policies or contracts. All Missouri
9 group contracts issued or renewed on or after December 31, 1984, shall be subject to this section.
10 Notwithstanding any construction or relationship of interdependent contracts or plans affecting
11 coverage and payment of reimbursement prerequisites under the policy or contract, coverage
12 required by this section shall be included in the policy or contract and payment provided as for
13 other coverage in the same policy or contract.
14 2. The offer of benefits under subsection 1 of this section shall be in writing and may be
15 rejected by the individual or group policyholder.
16 3. Nothing in this section shall prohibit the insurance company or not-for-profit health
17 service corporation from including any coverage for loss or impairment of speech, language or
18 hearing as standard coverage in their policies or contracts, but same shall not contain terms
19 contrary to this section.
20 4. The phrase "loss or impairment of speech or hearing" shall include those
21 communicative disorders generally treated by a speech pathologist, audiologist or
22 speech/language pathologist licensed by the state board of healing arts or certified by the
23 American Speech-Language and Hearing Association (ASHA), or both, and which fall within
24 the scope of his or her license or certification.
25 5. Any provision in a health insurance policy contrary to or in conflict with the
26 provisions of this section shall, to the extent of the conflict, be void, but such invalidity shall not
27 offset the validity of the other provisions of such policy.

28 6. The department of insurance, financial institutions and professional registration may
29 issue rules necessary to carry out the provisions of this section. No rule or portion of a rule
30 promulgated under the authority of this section shall become effective unless it has been
31 promulgated pursuant to the provisions of section 536.024.

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

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

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

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

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

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

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

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

376.811. 1. Every insurance company and health services corporation doing business
2 in this state shall offer in all health insurance policies benefits or coverage for chemical
3 dependency meeting the following minimum standards:
4 (1) Coverage for outpatient treatment through a nonresidential treatment program, or
5 through partial- or full-day program services, of not less than twenty-six days per policy benefit
6 period;
7 (2) Coverage for residential treatment program of not less than twenty-one days per
8 policy benefit period;
9 (3) Coverage for medical or social setting detoxification of not less than six days per
10 policy benefit period;
11 (4) Coverage for medication-assisted treatment for substance use disorders for use in
12 treating such patient's condition, including opioid-use and heroin-use disorders;
13 (5) The coverages set forth in this subsection may be subject to a separate lifetime
14 frequency cap of not less than ten episodes of treatment, except that such separate lifetime
15 frequency cap shall not apply to medical detoxification in a life-threatening situation as
16 determined by the treating physician and subsequently documented within forty-eight hours of
17 treatment to the reasonable satisfaction of the insurance company or health services corporation;
18 and
19 (6) The coverages set forth in this subsection:
20 (a) Shall be subject to the same coinsurance, co-payment and deductible factors as apply
21 to physical illness;
22 (b) May be administered pursuant to a managed care program established by the
23 insurance company or health services corporation; and
24 (c) May deliver covered services through a system of contractual arrangements with one
25 or more providers, hospitals, nonresidential or residential treatment programs, or other mental
26 health service delivery entities certified by the department of mental health, or accredited by a
27 nationally recognized organization, or licensed by the state of Missouri.
28 2. In addition to the coverages set forth in subsection 1 of this section, every insurance
29 company, health services corporation and health maintenance organization doing business in this
30 state shall offer in all health insurance policies, benefits or coverages for recognized mental
31 illness, excluding chemical dependency, meeting the following minimum standards:
32 (1) Coverage for outpatient treatment, including treatment through partial- or full-day
33 program services, for mental health services for a recognized mental illness rendered by a
34 licensed professional to the same extent as any other illness;

35 (2) Coverage for residential treatment programs for the therapeutic care and treatment
36 of a recognized mental illness when prescribed by a licensed professional and rendered in a
37 psychiatric residential treatment center licensed by the department of mental health or accredited
38 by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness;
39 (3) Coverage for inpatient hospital treatment for a recognized mental illness to the same
40 extent as for any other illness, not to exceed ninety days per year;
41 (4) The coverages set forth in this subsection shall be subject to the same coinsurance,
42 co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical
43 illness; and
44 (5) The coverages set forth in this subsection may be administered pursuant to a
45 managed care program established by the insurance company, health services corporation or
46 health maintenance organization, and covered services may be delivered through a system of
47 contractual arrangements with one or more providers, community mental health centers,
48 hospitals, nonresidential or residential treatment programs, or other mental health service
49 delivery entities certified by the department of mental health, or accredited by a nationally
50 recognized organization, or licensed by the state of Missouri.
51 3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the
52 group or individual policyholder or contract holder and, if accepted, shall fully and completely
53 satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to
54 376.814 shall prohibit an insurance company, health services corporation or health maintenance
55 organization from including all or part of the coverages set forth in sections 376.810 to 376.814
56 as standard coverage in their policies or contracts issued in this state.
57 4. Every insurance company, health services corporation and health maintenance
58 organization doing business in this state shall offer in all health insurance policies mental health
59 benefits or coverage as part of the policy or as a supplement to the policy. Such mental health
60 benefits or coverage shall include at least two sessions per year to a licensed psychiatrist,
61 licensed psychologist, licensed professional counselor, licensed clinical social worker, or, subject
62 to contractual provisions, a licensed marital and family therapist, acting within the scope of such
63 license and under the following minimum standards:
64 (1) Coverage and benefits in this subsection shall be for the purpose of diagnosis or
65 assessment, but not dependent upon findings; and
66 (2) Coverage and benefits in this subsection shall not be subject to any conditions of
67 preapproval, and shall be deemed reimbursable as long as the provisions of this subsection are
68 satisfied; and

69 (3) Coverage and benefits in this subsection shall be subject to the same coinsurance,
70 co-payment and deductible factors as apply to regular office visits under coverages and benefits
71 for physical illness.
72 5. If the group or individual policyholder or contract holder rejects the offer required by
73 this section, then the coverage shall be governed by the mental health and chemical dependency
74 insurance act as provided in sections 376.825 to 376.836.
75 6. This section shall not apply to a supplemental insurance policy, including a life care
76 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
77 benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care
78 policy, short-term major medical policy **[**~~of six months or less duration~~**] having a duration of**
79 **less than one year**, or any other supplemental policy as determined by the director of the
80 department of insurance, financial institutions and professional registration.

376.845. 1. For the purposes of this section the following terms shall mean:
2 (1) "Eating disorder", pica, rumination disorder, avoidant/restrictive food intake disorder,
3 anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding or eating
4 disorder, and any other eating disorder contained in the most recent version of the Diagnostic and
5 Statistical Manual of Mental Disorders published by the American Psychiatric Association where
6 diagnosed by a licensed physician, psychiatrist, psychologist, clinical social worker, licensed
7 marital and family therapist, or professional counselor duly licensed in the state where he or she
8 practices and acting within their applicable scope of practice in the state where he or she
9 practices;
10 (2) "Health benefit plan", shall have the same meaning as such term is defined in section
11 376.1350; however, for purposes of this section "health benefit plan" does not include a
12 supplemental insurance policy, including a life care contract, accident-only policy, specified
13 disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy,
14 long-term care policy, short-term major medical policy **[**~~of six months or less duration~~**] having**
15 **a duration of less than one year**, or any other supplemental policy;
16 (3) "Health carrier", shall have the same meaning as such term is defined in section
17 376.1350;
18 (4) "Medical care", health care services needed to diagnose, prevent, treat, cure, or
19 relieve physical manifestations of an eating disorder, and shall include inpatient hospitalization,
20 partial hospitalization, residential care, intensive outpatient treatment, follow-up outpatient care,
21 and counseling;
22 (5) "Pharmacy care", medications prescribed by a licensed physician for an eating
23 disorder and includes any health-related services deemed medically necessary to determine the

24 need or effectiveness of the medications, but only to the extent that such medications are
25 included in the insured's health benefit plan;

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

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

34 (8) "Treatment of eating disorders", therapy provided by a licensed treating physician,
35 psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and
36 family therapist pursuant to the powers granted under such licensed physician's, psychiatrist's,
37 psychologist's, professional counselor's, clinical social worker's, or licensed marital and family
38 therapist's license in the state where he or she practices for an individual diagnosed with an
39 eating disorder.

40 2. In accordance with the provisions of section 376.1550, all health benefit plans that are
41 delivered, issued for delivery, continued or renewed on or after January 1, 2017, if written inside
42 the state of Missouri, or written outside the state of Missouri but covering Missouri residents,
43 shall provide coverage for the diagnosis and treatment of eating disorders as required in section
44 376.1550.

45 3. Coverage provided under this section is limited to medically necessary treatment that
46 is provided by a licensed treating physician, psychiatrist, psychologist, professional counselor,
47 clinical social worker, or licensed marital and family therapist pursuant to the powers granted
48 under such licensed physician's, psychiatrist's, psychologist's, professional counselor's, clinical
49 social worker's, or licensed marital and family therapist's license and acting within their
50 applicable scope of coverage, in accordance with a treatment plan.

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

55 5. Coverage of the treatment of eating disorders may be subject to other general
56 exclusions and limitations of the contract or benefit plan not in conflict with the provisions of
57 this section, such as coordination of benefits, and utilization review of health care services,
58 which includes reviews of medical necessity and care management. Medical necessity
59 determinations and care management for the treatment of eating disorders shall consider the

60 overall medical and mental health needs of the individual with an eating disorder, shall not be
61 based solely on weight, and shall take into consideration the most recent Practice Guideline for
62 the Treatment of Patients with Eating Disorders adopted by the American Psychiatric
63 Association in addition to current standards based upon the medical literature generally
64 recognized as authoritative in the medical community.

376.1199. 1. Each health carrier or health benefit plan that offers or issues health benefit
2 plans providing obstetrical/gynecological benefits and pharmaceutical coverage, which are
3 delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002,
4 shall:
5 (1) Notwithstanding the provisions of subsection 4 of section 354.618, provide enrollees
6 with direct access to the services of a participating obstetrician, participating gynecologist or
7 participating obstetrician/gynecologist of her choice within the provider network for covered
8 services. The services covered by this subdivision shall be limited to those services defined by
9 the published recommendations of the accreditation council for graduate medical education for
10 training an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to
11 diagnosis, treatment and referral for such services. A health carrier shall not impose additional
12 co-payments, coinsurance or deductibles upon any enrollee who seeks or receives health care
13 services pursuant to this subdivision, unless similar additional co-payments, coinsurance or
14 deductibles are imposed for other types of health care services received within the provider
15 network. Nothing in this subsection shall be construed to require a health carrier to perform,
16 induce, pay for, reimburse, guarantee, arrange, provide any resources for or refer a patient for an
17 abortion, as defined in section 188.015, other than a spontaneous abortion or to prevent the death
18 of the female upon whom the abortion is performed, or to supersede or conflict with section
19 376.805; and
20 (2) Notify enrollees annually of cancer screenings covered by the enrollees' health benefit
21 plan and the current American Cancer Society guidelines for all cancer screenings or notify
22 enrollees at intervals consistent with current American Cancer Society guidelines of cancer
23 screenings which are covered by the enrollees' health benefit plans. The notice shall be delivered
24 by mail unless the enrollee and health carrier have agreed on another method of notification; and
25 (3) Include coverage for services related to diagnosis, treatment and appropriate
26 management of osteoporosis when such services are provided by a person licensed to practice
27 medicine and surgery in this state, for individuals with a condition or medical history for which
28 bone mass measurement is medically indicated for such individual. In determining whether
29 testing or treatment is medically appropriate, due consideration shall be given to peer-reviewed
30 medical literature. A policy, provision, contract, plan or agreement may apply to such services
31 the same deductibles, coinsurance and other limitations as apply to other covered services; and

32 (4) If the health benefit plan also provides coverage for pharmaceutical benefits, provide
33 coverage for contraceptives either at no charge or at the same level of deductible, coinsurance
34 or co-payment as any other covered drug.
35
36 No such deductible, coinsurance or co-payment shall be greater than any drug on the health
37 benefit plan's formulary. As used in this section, "contraceptive" shall include all prescription
38 drugs and devices approved by the federal Food and Drug Administration for use as a
39 contraceptive, but shall exclude all drugs and devices that are intended to induce an abortion, as
40 defined in section 188.015, which shall be subject to section 376.805. Nothing in this
41 subdivision shall be construed to exclude coverage for prescription contraceptive drugs or
42 devices ordered by a health care provider with prescriptive authority for reasons other than
43 contraceptive or abortion purposes.
44 2. For the purposes of this section, "health carrier" and "health benefit plan" shall have
45 the same meaning as defined in section 376.1350.
46 3. The provisions of this section shall not apply to a supplemental insurance policy,
47 including a life care contract, accident-only policy, specified disease policy, hospital policy
48 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
49 short-term major medical policy **[**~~of six months or less duration~~**] having a duration of less than**
50 **one year**, or any other supplemental policy as determined by the director of the department of
51 insurance, financial institutions and professional registration.
52 4. Notwithstanding the provisions of subdivision (4) of subsection 1 of this section to
53 the contrary:
54 (1) Any health carrier shall offer and issue to any person or entity purchasing a health
55 benefit plan, a health benefit plan that excludes coverage for contraceptives if the use or
56 provision of such contraceptives is contrary to the moral, ethical or religious beliefs or tenets of
57 such person or entity;
58 (2) Upon request of an enrollee who is a member of a group health benefit plan and who
59 states that the use or provision of contraceptives is contrary to his or her moral, ethical or
60 religious beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that
61 excludes coverage for contraceptives. Any administrative costs to a group health benefit plan
62 associated with such exclusion of coverage not offset by the decreased costs of providing
63 coverage shall be borne by the group policyholder or group plan holder;
64 (3) Any health carrier which is owned, operated or controlled in substantial part by an
65 entity that is operated pursuant to moral, ethical or religious tenets that are contrary to the use
66 or provision of contraceptives shall be exempt from the provisions of subdivision (4) of

67 subsection 1 of this section. For purposes of this subsection, if new premiums are charged for
68 a contract, plan or policy, it shall be determined to be a new contract, plan or policy.
69 5. Except for a health carrier that is exempted from providing coverage for
70 contraceptives pursuant to this section, a health carrier shall allow enrollees in a health benefit
71 plan that excludes coverage for contraceptives pursuant to subsection 4 of this section to
72 purchase a health benefit plan that includes coverage for contraceptives.
73 6. Any health benefit plan issued pursuant to subsection 1 of this section shall provide
74 clear and conspicuous written notice on the enrollment form or any accompanying materials to
75 the enrollment form and the group health benefit plan application and contract:
76 (1) Whether coverage for contraceptives is or is not included;
77 (2) That an enrollee who is a member of a group health benefit plan with coverage for
78 contraceptives has the right to exclude coverage for contraceptives if such coverage is contrary
79 to his or her moral, ethical or religious beliefs;
80 (3) That an enrollee who is a member of a group health benefit plan without coverage
81 for contraceptives has the right to purchase coverage for contraceptives;
82 (4) Whether an optional rider for elective abortions has been purchased by the group
83 contract holder pursuant to section 376.805; and
84 (5) That an enrollee who is a member of a group health plan with coverage for elective
85 abortions has the right to exclude and not pay for coverage for elective abortions if such coverage
86 is contrary to his or her moral, ethical, or religious beliefs.
87
88 For purposes of this subsection, if new premiums are charged for a contract, plan, or policy, it
89 shall be determined to be a new contract, plan, or policy.
90 7. Health carriers shall not disclose to the person or entity who purchased the health
91 benefit plan the names of enrollees who exclude coverage for contraceptives in the health benefit
92 plan or who purchase a health benefit plan that includes coverage for contraceptives. Health
93 carriers and the person or entity who purchased the health benefit plan shall not discriminate
94 against an enrollee because the enrollee excluded coverage for contraceptives in the health
95 benefit plan or purchased a health benefit plan that includes coverage for contraceptives.
96 8. The departments of health and senior services and insurance, financial institutions and
97 professional registration may promulgate rules necessary to implement the provisions of this
98 section. No rule or portion of a rule promulgated pursuant to this section shall become effective
99 unless it has been promulgated pursuant to chapter 536. Any rule or portion of a rule, as that
100 term is defined in section 536.010, that is created under the authority delegated in this section
101 shall become effective only if it complies with and is subject to all of the provisions of chapter
102 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any

103 of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the
104 effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the
105 grant of rulemaking authority and any rule proposed or adopted after August 28, 2001, shall be
106 invalid and void.

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

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

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

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

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

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

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

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

376.1209. 1. Each entity offering individual and group health insurance policies
2 providing coverage on an expense-incurred basis, individual and group service or indemnity type
3 contracts issued by a nonprofit corporation, individual and group service contracts issued by a
4 health maintenance organization, all self-insured group arrangements to the extent not preempted
5 by federal law, and all managed health care delivery entities of any type or description, that
6 provide coverage for the surgical procedure known as a mastectomy, and which are delivered,
7 issued for delivery, continued or renewed in this state on or after January 1, 1998, shall provide
8 coverage for prosthetic devices or reconstructive surgery necessary to restore symmetry as
9 recommended by the oncologist or primary care physician for the patient incident to the
10 mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the
11 same deductible and coinsurance conditions applied to the mastectomy and all other terms and
12 conditions applicable to other benefits with the exception that no time limit shall be imposed on
13 an individual for the receipt of prosthetic devices or reconstructive surgery and if such individual
14 changes his or her insurer, then the new policy subject to the federal Women's Health and Cancer
15 Rights Act (Sections 901-903 of P.L. 105-277), as amended, shall provide coverage consistent
16 with the federal Women's Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277), as
17 amended, and any regulations promulgated pursuant to such act.
18 2. As used in this section, the term "mastectomy" means the removal of all or part of the
19 breast for medically necessary reasons, as determined by a physician licensed pursuant to chapter
20 334.
21 3. The provisions of this section shall not apply to a supplemental insurance policy,
22 including a life care contract, accident-only policy, specified disease policy, hospital policy
23 providing a fixed daily benefit only, Medicare supplement policy**, short-term major medical**
24 **policy having a duration of less than one year,** or long-term care policy.

376.1210. 1. Each entity offering individual and group health insurance policies
2 providing coverage on an expense-incurred basis, individual and group service or indemnity type
3 contracts issued by a nonprofit corporation, individual and group service contracts issued by a
4 health maintenance organization, all self-insured group arrangements to the extent not preempted
5 by federal law, and all managed health care delivery entities of any type or description, that are
6 delivered, issued for delivery, continued or renewed in this state on or after January 1, 1997, and
7 providing for maternity benefits, shall provide coverage for a minimum of forty-eight hours of
8 inpatient care following a vaginal delivery and a minimum of ninety-six hours of inpatient care
9 following a cesarean section for a mother and her newly born child in a hospital as defined in
10 section 197.020 or any other health care facility licensed to provide obstetrical care under the
11 provisions of chapter 197.

12 2. Notwithstanding the provisions of subsection 1 of this section, any entity offering
13 individual and group health insurance policies providing coverage on an expense-incurred basis,
14 individual and group service or indemnity type contracts issued by a nonprofit corporation,
15 individual and group service contracts issued by a health maintenance organization, all self-
16 insured group arrangements to the extent not preempted by federal law, and all managed health
17 care delivery entities of any type or description that are delivered, issued for delivery, continued
18 or renewed in this state on or after January 1, 1997, and providing for maternity benefits, may
19 authorize a shorter length of hospital stay for services related to maternity and newborn care if:
20 (1) A shorter hospital stay meets with the approval of the attending physician after
21 consulting with the mother. The physician's approval to discharge shall be made in accordance
22 with the most current version of the "Guidelines for Perinatal Care" prepared by the American
23 Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar
24 guidelines prepared by another nationally recognized medical organization; and
25 (2) The entity providing the individual or group health insurance policy provides
26 coverage for post-discharge care to the mother and her newborn.
27 3. Post-discharge care shall consist of a minimum of two visits at least one of which shall
28 be in the home, in accordance with accepted maternal and neonatal physical assessments, by a
29 registered professional nurse with experience in maternal and child health nursing or a physician.
30 The location and schedule of the post-discharge visits shall be determined by the attending
31 physician. Services provided by the registered professional nurse or physician shall include, but
32 not be limited to, physical assessment of the newborn and mother, parent education, assistance
33 and training in breast or bottle feeding, education and services for complete childhood
34 immunizations, the performance of any necessary and appropriate clinical tests and submission
35 of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance
36 with the medical criteria outlined in the most current version of the "Guidelines for Perinatal
37 Care" prepared by the American Academy of Pediatrics and the American College of
38 Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized
39 medical organization. Any abnormality, in the condition of the mother or the child, observed by
40 the nurse shall be reported to the attending physician as medically appropriate.
41 4. For the purposes of this section, "attending physician" shall include the attending
42 obstetrician, pediatrician, or other physician attending the mother or newly born child.
43 5. Each entity offering individual and group health insurance policies providing coverage
44 on an expense-incurred basis, individual and group service or indemnity type contracts issued
45 by a nonprofit corporation, individual and group service contracts issued by a health maintenance
46 organization, all self-insured group arrangements to the extent not preempted by federal law and
47 all managed health care delivery entities of any type or description shall provide notice to

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

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

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

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

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

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

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

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

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

21 5. The department of health and senior services shall promulgate rules and regulations

22 to determine which immunizations shall be covered by policies, plans or contracts described in
23 this section. No rule or portion of a rule promulgated under the authority of this section shall
24 become effective unless it has been promulgated pursuant to the provisions of section 536.024.
25 6. No health care provider shall charge more than one hundred percent of the reasonable
26 and customary charges for providing any immunization.

376.1218. 1. Any health carrier or health benefit plan that offers or issues health benefit
2 plans, other than Medicaid health benefit plans, which are delivered, issued for delivery,
3 continued, or renewed in this state on or after January 1, 2006, shall provide coverage for early
4 intervention services described in this section that are delivered by early intervention specialists
5 who are health care professionals licensed by the state of Missouri and acting within the scope
6 of their professions for children from birth to age three identified by the Part C early intervention
7 system as eligible for services under Part C of the Individuals with Disabilities Education Act,
8 20 U.S.C. Section 1431, et seq. Such coverage shall be limited to three thousand dollars for each
9 covered child per policy per calendar year, with a maximum of nine thousand dollars per child.
10 2. As used in this section, "health carrier" and "health benefit plan" shall have the same
11 meaning as such terms are defined in section 376.1350.
12 3. In the event that any health benefit plan is found not to be required to provide
13 coverage under subsection 1 of this section because of preemption by a federal law, including
14 but not limited to the act commonly known as ERISA contained in Title 29 of the United States
15 Code, or in the event that subsection 1 of this section is found to be unconstitutional, then the
16 lead agency shall be responsible for payment and provision of any benefit provided under this
17 section.
18 4. For purposes of this section, "early intervention services" means medically necessary
19 speech and language therapy, occupational therapy, physical therapy, and assistive technology
20 devices for children from birth to age three who are identified by the Part C early intervention
21 system as eligible for services under Part C of the Individuals with Disabilities Education Act,
22 20 U.S.C. Section 1431, et seq. Early intervention services shall include services under an active
23 individualized family service plan that enhance functional ability without effecting a cure. An
24 individualized family service plan is a written plan for providing early intervention services to
25 an eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section
26 1436. The Part C early intervention system, on behalf of its contracted regional Part C early
27 intervention system centers and providers, shall be considered the rendering provider of services
28 for purposes of this section.
29 5. No payment made for specified early intervention services shall be applied by the
30 health carrier or health benefit plan against any maximum lifetime aggregate specified in the
31 policy or health benefit plan if the carrier opts to satisfy its obligations under this section under

32 subdivision (2) of subsection 7 of this section. A health benefit plan shall be billed at the
33 applicable Medicaid rate at the time the covered benefit is delivered, and the health benefit plan
34 shall pay the Part C early intervention system at such rate for benefits covered by this section.
35 Services under the Part C early intervention system shall be delivered as prescribed by the
36 individualized family service plan and an electronic claim filed in accordance with the carrier's
37 or plan's standard format. Beginning January 1, 2007, such claims' payments shall be made in
38 accordance with the provisions of sections 376.383 and 376.384.
39 6. The health care service required by this section shall not be subject to any greater
40 deductible, co-payment, or coinsurance than other similar health care services provided by the
41 health benefit plan.
42 7. (1) Subject to the provisions of this section, payments made during a calendar year
43 by a health carrier or group of carriers affiliated by or under common ownership or control to the
44 Part C early intervention system for services provided to children covered by the Part C early
45 intervention system shall not exceed one-half of one percent of the direct written premium for
46 health benefit plans as reported to the department of insurance, financial institutions and
47 professional registration on the health carrier's most recently filed annual financial statement.
48 (2) In lieu of reimbursing claims under this section, a carrier or group of carriers
49 affiliated by or under common ownership or control may, on behalf of all of the carrier's or
50 carriers' health benefit plan or plans providing coverage under this section, directly pay the Part
51 C early intervention system by January thirty-first of the calendar year an amount equal to
52 one-half of one percent of the direct written premium for health benefit plans as reported to the
53 department of insurance, financial institutions and professional registration on the health carrier's
54 most recently filed annual financial statement, or five hundred thousand dollars, whichever is
55 less, and such payment shall constitute full and complete satisfaction of the health benefit plan's
56 obligation for the calendar year. Nothing in this subsection shall require a health carrier or health
57 benefit plan providing coverage under this section to amend or modify any provision of an
58 existing policy or plan relating to the payment or reimbursement of claims by the health carrier
59 or health benefit plan.
60 8. This section shall not apply to a supplemental insurance policy, including a life care
61 contract, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare
62 supplement policy, hospitalization-surgical care policy, policy that is individually underwritten
63 or provides such coverage for specific individuals and members of their families, long-term care
64 policy, or short-term major medical policies **[**~~of six months or less duration~~**] having a duration**
65 **of less than one year**.
66 9. Except for health carriers or health benefit plans making payments under subdivision
67 (2) of subsection 7 of this section, the department of insurance, financial institutions and

68 professional registration shall collect data related to the number of children receiving private
69 insurance coverage under this section and the total amount of moneys paid on behalf of such
70 children by private health carriers or health benefit plans. The department shall report to the
71 general assembly regarding the department's findings no later than January 30, 2007, and
72 annually thereafter.
73 10. Notwithstanding the provisions of section 23.253 to the contrary, the provisions of
74 this section shall not sunset.

376.1219. 1. Each policy issued by an entity offering individual and group health
2 insurance which provides coverage on an expense-incurred basis, individual and group health
3 service or indemnity type contracts issued by a nonprofit corporation, individual and group
4 service contracts issued by a health maintenance organization, all self-insured group health
5 arrangements to the extent not preempted by federal law, and all health care plans provided by
6 managed health care delivery entities of any type or description, that are delivered, issued for
7 delivery, continued or renewed in this state on or after September 1, 1997, shall provide coverage
8 for formula and low protein modified food products recommended by a physician for the
9 treatment of a patient with phenylketonuria or any inherited disease of amino and organic acids
10 who is covered under the policy, contract, or plan and who is less than six years of age.
11 2. For purposes of this section, "low protein modified food products" means foods that
12 are specifically formulated to have less than one gram of protein per serving and are intended to
13 be used under the direction of a physician for the dietary treatment of any inherited metabolic
14 disease. Low protein modified food products do not include foods that are naturally low in
15 protein.
16 3. The coverage required by this section may be subject to the same deductible for
17 similar health care services provided by the policy, contract, or plan as well as a reasonable
18 coinsurance or co-payment on the part of the insured, which shall not be greater than fifty percent
19 of the cost of the formula and food products, and may be subject to an annual benefit maximum
20 of not less than five thousand dollars per covered child. Nothing in this section shall prohibit
21 a carrier from using individual case management or from contracting with vendors of the formula
22 and food products.
23 4. This section shall not apply to a supplemental insurance policy, including a life care
24 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
25 benefit only, Medicare supplement policy, long-term care policy, **short-term major medical**
26 **policy having a duration of less than one year,** or any other supplemental policy as determined
27 by the director of the department of insurance, financial institutions and professional registration.

376.1220. 1. Each policy issued by an entity offering individual and group health
2 insurance which provides coverage on an expense-incurred basis, individual or group health

3 service, or indemnity contracts issued by a nonprofit corporation, individual and group service
4 contracts issued by a health maintenance organization, all self-insured group health arrangements
5 to the extent not preempted by federal law, and all health care plans provided by managed health
6 care delivery entities of any type or description that are delivered, issued for delivery, continued
7 or renewed in this state shall provide coverage for newborn hearing screening, necessary
8 rescreening, audiological assessment and follow-up, and initial amplification.
9 2. The health care service required by this section shall not be subject to any greater
10 deductible or co-payment than other similar health care services provided by the policy, contract
11 or plan.
12 3. This section shall not apply to a supplemental insurance policy, including a life care
13 contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily
14 benefit only, Medicare supplement policy, long-term care policy, short-term major medical
15 policies **[**~~of six months or less duration~~**] having a duration of less than one year**, or any other
16 supplemental policy as determined by the director of the department of insurance, financial
17 institutions and professional registration.
18 4. Coverage for newborn hearing screening and any necessary rescreening and
19 audiological assessment shall be provided to newborns eligible for medical assistance pursuant
20 to section 208.151, and the children's health program pursuant to sections 208.631 to 208.660,
21 with payment for the newborn hearing screening required in section 191.925, and any necessary
22 rescreening, audiological assessment and follow-up, and amplification as described in section
23 191.928.
376.1224. 1. For purposes of this section, the following terms shall mean:
2 (1) "Applied behavior analysis", the design, implementation, and evaluation of
3 environmental modifications, using behavioral stimuli and consequences, to produce socially
4 significant improvement in human behavior, including the use of direct observation,
5 measurement, and functional analysis of the relationships between environment and behavior;
6 (2) "Autism service provider":
7 (a) Any person, entity, or group that provides diagnostic or treatment services for autism
8 spectrum disorders who is licensed or certified by the state of Missouri; or
9 (b) Any person who is licensed under chapter 337 as a board-certified behavior analyst
10 by the behavior analyst certification board or licensed under chapter 337 as an assistant
11 board-certified behavior analyst;
12 (3) "Autism spectrum disorders", a neurobiological disorder, an illness of the nervous
13 system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental
14 Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as

15 defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders
16 of the American Psychiatric Association;
17 (4) "Diagnosis of autism spectrum disorders", medically necessary assessments,
18 evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder;
19 (5) "Habilitative or rehabilitative care", professional, counseling, and guidance services
20 and treatment programs, including applied behavior analysis, that are necessary to develop the
21 functioning of an individual;
22 (6) "Health benefit plan", shall have the same meaning ascribed to it as in section
23 376.1350;
24 (7) "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;
25 (8) "Line therapist", an individual who provides supervision of an individual diagnosed
26 with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed
27 treatment plan, and implements specific behavioral interventions as outlined in the behavior plan
28 under the direct supervision of a licensed behavior analyst;
29 (9) "Pharmacy care", medications used to address symptoms of an autism spectrum
30 disorder prescribed by a licensed physician, and any health-related services deemed medically
31 necessary to determine the need or effectiveness of the medications only to the extent that such
32 medications are included in the insured's health benefit plan;
33 (10) "Psychiatric care", direct or consultative services provided by a psychiatrist licensed
34 in the state in which the psychiatrist practices;
35 (11) "Psychological care", direct or consultative services provided by a psychologist
36 licensed in the state in which the psychologist practices;
37 (12) "Therapeutic care", services provided by licensed speech therapists, occupational
38 therapists, or physical therapists;
39 (13) "Treatment for autism spectrum disorders", care prescribed or ordered for an
40 individual diagnosed with an autism spectrum disorder by a licensed physician or licensed
41 psychologist, including equipment medically necessary for such care, pursuant to the powers
42 granted under such licensed physician's or licensed psychologist's license, including, but not
43 limited to:
44 (a) Psychiatric care;
45 (b) Psychological care;
46 (c) Habilitative or rehabilitative care, including applied behavior analysis therapy;
47 (d) Therapeutic care;
48 (e) Pharmacy care.
49 2. All group health benefit plans that are delivered, issued for delivery, continued, or
50 renewed on or after January 1, 2011, if written inside the state of Missouri, or written outside the

51 state of Missouri but insuring Missouri residents, shall provide coverage for the diagnosis and
52 treatment of autism spectrum disorders to the extent that such diagnosis and treatment is not
53 already covered by the health benefit plan.
54 3. With regards to a health benefit plan, a health carrier shall not deny or refuse to issue
55 coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise
56 terminate or restrict coverage on an individual or their dependent because the individual is
57 diagnosed with autism spectrum disorder.
58 4. (1) Coverage provided under this section is limited to medically necessary treatment
59 that is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to
60 the powers granted under such licensed physician's or licensed psychologist's license, in
61 accordance with a treatment plan.
62 (2) The treatment plan, upon request by the health benefit plan or health carrier, shall
63 include all elements necessary for the health benefit plan or health carrier to pay claims. Such
64 elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and
65 duration of treatment, and goals.
66 (3) Except for inpatient services, if an individual is receiving treatment for an autism
67 spectrum disorder, a health carrier shall have the right to review the treatment plan not more than
68 once every six months unless the health carrier and the individual's treating physician or
69 psychologist agree that a more frequent review is necessary. Any such agreement regarding the
70 right to review a treatment plan more frequently shall only apply to a particular individual being
71 treated for an autism spectrum disorder and shall not apply to all individuals being treated for
72 autism spectrum disorders by a physician or psychologist. The cost of obtaining any review or
73 treatment plan shall be borne by the health benefit plan or health carrier, as applicable.
74 5. Coverage provided under this section for applied behavior analysis shall be subject
75 to a maximum benefit of forty thousand dollars per calendar year for individuals through
76 eighteen years of age. Such maximum benefit limit may be exceeded, upon prior approval by
77 the health benefit plan, if the provision of applied behavior analysis services beyond the
78 maximum limit is medically necessary for such individual. Payments made by a health carrier
79 on behalf of a covered individual for any care, treatment, intervention, service or item, the
80 provision of which was for the treatment of a health condition unrelated to the covered
81 individual's autism spectrum disorder, shall not be applied toward any maximum benefit
82 established under this subsection. Any coverage required under this section, other than the
83 coverage for applied behavior analysis, shall not be subject to the age and dollar limitations
84 described in this subsection.
85 6. The maximum benefit limitation for applied behavior analysis described in subsection
86 5 of this section shall be adjusted by the health carrier at least triennially for inflation to reflect

87 the aggregate increase in the general price level as measured by the Consumer Price Index for
88 All Urban Consumers for the United States, or its successor index, as defined and officially
89 published by the United States Department of Labor, or its successor agency. Beginning January
90 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied
91 behavior analysis coverage adjusted for inflation in accordance with this subsection shall be
92 calculated by the director of the department of insurance, financial institutions and professional
93 registration. The director shall furnish the calculated value to the secretary of state, who shall
94 publish such value in the Missouri Register as soon after each January first as practicable, but
95 it shall otherwise be exempt from the provisions of section 536.021.
96 7. Subject to the provisions set forth in subdivision (3) of subsection 4 of this section,
97 coverage provided under this section shall not be subject to any limits on the number of visits
98 an individual may make to an autism service provider, except that the maximum total benefit for
99 applied behavior analysis set forth in subsection 5 of this section shall apply to this subsection.
100 8. This section shall not be construed as limiting benefits which are otherwise available
101 to an individual under a health benefit plan. The health care coverage required by this section
102 shall not be subject to any greater deductible, coinsurance, or co-payment than other physical
103 health care services provided by a health benefit plan. Coverage of services may be subject to
104 other general exclusions and limitations of the contract or benefit plan, not in conflict with the
105 provisions of this section, such as coordination of benefits, exclusions for services provided by
106 family or household members, and utilization review of health care services, including review
107 of medical necessity and care management; however, coverage for treatment under this section
108 shall not be denied on the basis that it is educational or habilitative in nature.
109 9. To the extent any payments or reimbursements are being made for applied behavior
110 analysis, such payments or reimbursements shall be made to either:
111 (1) The autism service provider, as defined in this section; or
112 (2) The entity or group for whom such supervising person, who is certified as a
113 board-certified behavior analyst by the Behavior Analyst Certification Board, works or is
114 associated.
115
116 Such payments or reimbursements under this subsection to an autism service provider or a
117 board-certified behavior analyst shall include payments or reimbursements for services provided
118 by a line therapist under the supervision of such provider or behavior analyst if such services
119 provided by the line therapist are included in the treatment plan and are deemed medically
120 necessary.
121 10. Notwithstanding any other provision of law to the contrary, health carriers shall not
122 be held liable for the actions of line therapists in the performance of their duties.

123 11. The provisions of this section shall apply to any health care plans issued to
124 employees and their dependents under the Missouri consolidated health care plan established
125 pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state
126 on or after January 1, 2011. The terms "employees" and "health care plans" shall have the same
127 meaning ascribed to them in section 103.003.
128 12. The provisions of this section shall also apply to the following types of plans that are
129 established, extended, modified, or renewed on or after January 1, 2011:
130 (1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section
131 1002(32);
132 (2) All self-insured group arrangements, to the extent not preempted by federal law;
133 (3) All plans provided through a multiple employer welfare arrangement, or plans
134 provided through another benefit arrangement, to the extent permitted by the Employee
135 Retirement Income Security Act of 1974, or any waiver or exception to that act provided under
136 federal law or regulation; and
137 (4) All self-insured school district health plans.
138 13. The provisions of this section shall not automatically apply to an individually
139 underwritten health benefit plan, but shall be offered as an option to any such plan.
140 14. The provisions of this section shall not apply to a supplemental insurance policy,
141 including a life care contract, accident-only policy, specified disease policy, hospital policy
142 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
143 short-term major medical policy **[**~~of six months or less duration~~**] having a duration of less than**
144 **one year**, or any other supplemental policy.
145 15. Any health carrier or other entity subject to the provisions of this section shall not
146 be required to provide reimbursement for the applied behavior analysis delivered to a person
147 insured by such health carrier or other entity to the extent such health carrier or other entity is
148 billed for such services by any Part C early intervention program or any school district for
149 applied behavior analysis rendered to the person covered by such health carrier or other entity.
150 This section shall not be construed as affecting any obligation to provide services to an
151 individual under an individualized family service plan, an individualized education plan, or an
152 individualized service plan. This section shall not be construed as affecting any obligation to
153 provide reimbursement pursuant to section 376.1218.
154 16. The provisions of sections 376.383, 376.384, and 376.1350 to 376.1399 shall apply
155 to this section.
156 17. The director of the department of insurance, financial institutions and professional
157 registration shall grant a small employer with a group health plan, as that term is defined in
158 section 379.930, a waiver from the provisions of this section if the small employer demonstrates

159 to the director by actual claims experience over any consecutive twelve-month period that
160 compliance with this section has increased the cost of the health insurance policy by an amount
161 of two and a half percent or greater over the period of a calendar year in premium costs to the
162 small employer.
163 18. The provisions of this section shall not apply to the Mo HealthNet program as
164 described in chapter 208.
165 19. (1) By February 1, 2012, and every February first thereafter, the department of
166 insurance, financial institutions and professional registration shall submit a report to the general
167 assembly regarding the implementation of the coverage required under this section. The report
168 shall include, but shall not be limited to, the following:
169 (a) The total number of insureds diagnosed with autism spectrum disorder;
170 (b) The total cost of all claims paid out in the immediately preceding calendar year for
171 coverage required by this section;
172 (c) The cost of such coverage per insured per month; and
173 (d) The average cost per insured for coverage of applied behavior analysis;
174 (2) All health carriers and health benefit plans subject to the provisions of this section
175 shall provide the department with the data requested by the department for inclusion in the
176 annual report.
376.1225. 1. All individual and group health insurance policies providing coverage on
2 an expense-incurred basis, individual and group service or indemnity type contracts issued by
3 a nonprofit corporation, individual and group service contracts issued by a health maintenance
4 organization, all self-insured group arrangements to the extent not preempted by federal law and
5 all managed health care delivery entities of any type or description, that are delivered, issued for
6 delivery, continued or renewed on or after August 28, 1998, shall provide coverage for
7 administration of general anesthesia and hospital charges for dental care provided to the
8 following covered persons:
9 (1) A child under the age of five;
10 (2) A person who is severely disabled; or
11 (3) A person who has a medical or behavioral condition which requires hospitalization
12 or general anesthesia when dental care is provided.
13 2. Each plan as described in this section must provide coverage for administration of
14 general anesthesia and hospital or office charges for treatment rendered by a dentist, regardless
15 of whether the services are provided in a participating hospital or surgical center or office.
16 3. Nothing in this section shall prevent a health carrier from requiring prior authorization
17 for hospitalization for dental care procedures in the same manner that prior authorization is
18 required for hospitalization for other covered diseases or conditions.

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

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

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

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

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

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

376.1232. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2010, shall offer coverage for prosthetic devices and services, including original and

replacement devices, as prescribed by a physician acting within the scope of his or her practice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 2. Coverage and benefits related to the examinations and tests as required by this section
17 shall be at least as favorable and subject to the same dollar limits, deductible, and co-payments
18 as other covered benefits or services.
19 3. Nothing in this act shall apply to accident-only, hospital indemnity, Medicare
20 supplement, long-term care, or other limited benefit health insurance policies.
21 4. The provisions of this section shall not apply to short-term major medical policies **[**~~of~~
22 ~~six months or less duration~~**] having a duration of less than one year**.
23 5. The attending physician shall advise the patient of the advantages, disadvantages, and
24 risks, including cancer, associated with breast implantation prior to such operation.
25 6. Nothing in this section shall alter, impair or otherwise affect claims, rights or remedies
26 available pursuant to law.

376.1253. 1. Each physician attending any patient with a newly diagnosed cancer shall
2 inform the patient that the patient has the right to a referral for a second opinion by an
3 appropriate board-certified specialist prior to any treatment. If no specialist in that specific
4 cancer diagnosis area is in the provider network, a referral shall be made to a nonnetwork
5 specialist in accordance with this section.
6 2. Each health carrier or health benefit plan, as defined in section 376.1350, that offers
7 or issues health benefit plans which are delivered, issued for delivery, continued or renewed in
8 this state on or after January 1, 2003, shall provide coverage for a second opinion rendered by
9 a specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer
10 is referred to such specialist by his or her attending physician. Such coverage shall be subject
11 to the same deductible and coinsurance conditions applied to other specialist referrals and all
12 other terms and conditions applicable to other benefits, including the prior authorization and/or
13 referral authorization requirements as specified in the applicable health insurance policy.
14 3. The provisions of this section shall not apply to a supplemental insurance policy,
15 including a life care contract, accident-only policy, specified disease policy, hospital policy
16 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
17 short-term major medical policies **[**~~of six months' or less duration~~**] having a duration of less
18 than one year**, or any other supplemental policy as determined by the director of the department
19 of insurance, financial institutions and professional registration.

376.1257. 1. As used in this section the following terms shall mean:
2 (1) "Anticancer medications", medications used to kill or slow the growth of cancerous
3 cells;
4 (2) "Covered person", a policyholder, subscriber, enrollee, or other individual enrolled
5 in or insured by a health benefit plan for health insurance coverage;
6 (3) "Health benefit plan", shall have the same meaning as defined in section 376.1350.

7 2. Any health benefit plan that provides coverage and benefits for cancer treatment shall
8 provide coverage of prescribed orally administered anticancer medications on a basis no less
9 favorable than intravenously administered or injected anticancer medications.
10 3. Coverage of orally administered anticancer medication shall not be subject to any prior
11 authorization, dollar limit, co-payment, deductible, or other out-of-pocket expense that does not
12 apply to intravenously administered or injected anticancer medication, regardless of formulation
13 or benefit category determination by the company administering the health benefit plan.
14 4. The health benefit plan shall not reclassify or increase any type of cost-sharing to the
15 covered person for anticancer medications in order to achieve compliance with this section. Any
16 change in health insurance coverage, which otherwise increases an out-of-pocket expense to
17 anticancer medications, shall be applied to the majority of comparable medical or pharmaceutical
18 benefits covered by the health benefit plan.
19 5. Notwithstanding the provisions of subsections 2, 3, and 4 of this section, a health
20 benefit plan that limits the total amounts paid by a covered person through all cost-sharing
21 requirements to no more than seventy-five dollars per thirty-day supply for any orally
22 administered anticancer medication shall be considered in compliance with this section. On
23 January 1, 2016, and on January first of each year thereafter, a health benefit plan may adjust
24 such seventy-five dollar limit. The adjustment shall not exceed the Consumer Price Index for
25 All Urban Consumers Midwest Region for that year. For purposes of this subsection "cost-
26 sharing requirements" shall include co-payments, coinsurance, deductibles, and any other
27 amounts paid by the covered person for that prescription.
28 6. For a health benefit plan that meets the definition of "high deductible health plan" as
29 defined by 26 U.S.C. 223(c)(2), the provisions of subsection 5 of this section shall only apply
30 after a covered person's deductible has been satisfied for the year.
31 7. **The provisions of this section shall not apply to short-term major medical policies**
32 **having a duration of less than one year.**
33 **8.** The provisions of this section shall become effective January 1, 2015.
376.1275. 1. Each health carrier or health benefit plan that offers or issues health benefit
2 plans which are delivered, issued for delivery, continued, or renewed in this state on or after
3 January 1, 2003, shall include coverage for their members for the cost for human leukocyte
4 antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR
5 antigens for utilization in bone marrow transplantation. The testing must be performed in a
6 facility which is accredited by the American Association of Blood Banks or its successors, and
7 is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended,
8 and is accredited by the American Association of Blood Banks or its successors, the College of
9 American Pathologists, the American Society for Histocompatibility and Immunogenetics

10 (ASHI) or any other national accrediting body with requirements that are substantially equivalent
11 to or more stringent than those of the College of American Pathologists. At the time of testing,
12 the person being tested must complete and sign an informed consent form which also authorizes
13 the results of the test to be used for participation in the National Marrow Donor Program. The
14 health benefit plan may limit each enrollee to one such testing per lifetime to be reimbursed at
15 a cost of no greater than seventy-five dollars by the health carrier or health benefit plan.
16 2. For the purposes of this section, "health carrier" and "health benefit plan" shall have
17 the same meaning as defined in section 376.1350.
18 3. The health care service required by this section shall not be subject to any greater
19 deductible or co-payment than other similar health care services provided by the health benefit
20 plan.
21 4. The provisions of this section shall not apply to a supplemental insurance policy,
22 including a life care contract, accident-only policy, specified disease policy, hospital policy
23 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
24 short-term major medical policies **[**~~of six months' or less duration~~**] having a duration of less**
25 **than one year**, or any other supplemental policy as determined by the director of the department
26 of insurance, financial institutions and professional registration.

376.1290. 1. Each entity offering individual and group health insurance policies
2 providing coverage on an expense-incurred basis, individual and group service or indemnity type
3 contracts issued by a health services corporation, individual and group service contracts issued
4 by a health maintenance organization, all self-insured group arrangements, to the extent not
5 preempted by federal law, and all managed health care delivery entities of any type or description
6 that are delivered, issued for delivery, continued or renewed in this state on or after January 1,
7 2002, shall offer coverage for testing pregnant women for lead poisoning and for all testing for
8 lead poisoning authorized by sections 701.340 to 701.349 or by rule of the department of health
9 and senior services promulgated pursuant to sections 701.340 to 701.349.
10 2. Health care services required by this section shall not be subject to any greater
11 deductible or co-payment than any other health care service provided by the policy, contract or
12 plan.
13 3. No entity enumerated in subsection 1 of this section shall reduce or eliminate coverage
14 as a result of the requirements of this section.
15 4. Nothing in this section shall apply to **short-term major medical policies having a**
16 **duration of less than one year, or to** accident-only, specified disease, hospital indemnity,
17 Medicare supplement, long-term care or other limited benefit health insurance policies.

376.1400. 1. Every health insurance carrier offering policies of insurance in this state
2 shall use standardized information for the explanation of benefits given to the health care

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

8 2. The standardized information shall contain the following:
9 (1) The name of the insured;
10 (2) The insured's identification number;
11 (3) The date of service;
12 (4) Amount of charge;
13 (5) Explanation for any denial;
14 (6) The amount paid;
15 (7) The patient's full name;
16 (8) The name and address of the insurer; and
17 (9) The phone number to contact for questions on explanation of benefits.
18 3. All health insurance carriers shall use the standard explanation of benefits information
19 after January 1, 2002.

376.1550. 1. Notwithstanding any other provision of law to the contrary, each health
2 carrier that offers or issues health benefit plans which are delivered, issued for delivery,
3 continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a
4 mental health condition, as defined in this section, and shall comply with the following
5 provisions:
6 (1) A health benefit plan shall provide coverage for treatment of a mental health
7 condition and shall not establish any rate, term, or condition that places a greater financial burden
8 on an insured for access to treatment for a mental health condition than for access to treatment
9 for a physical health condition. Any deductible or out-of-pocket limits required by a health
10 carrier or health benefit plan shall be comprehensive for coverage of all health conditions,
11 whether mental or physical;
12 (2) The coverages set forth is this subsection:
13 (a) May be administered pursuant to a managed care program established by the health
14 carrier; and
15 (b) May deliver covered services through a system of contractual arrangements with one
16 or more providers, hospitals, nonresidential or residential treatment programs, or other mental
17 health service delivery entities certified by the department of mental health, or accredited by a
18 nationally recognized organization, or licensed by the state of Missouri;

19 (3) A health benefit plan that does not otherwise provide for management of care under
20 the plan or that does not provide for the same degree of management of care for all health
21 conditions may provide coverage for treatment of mental health conditions through a managed
22 care organization; provided that the managed care organization is in compliance with rules
23 adopted by the department of insurance, financial institutions and professional registration that
24 assure that the system for delivery of treatment for mental health conditions does not diminish
25 or negate the purpose of this section. The rules adopted by the director shall assure that:
26 (a) Timely and appropriate access to care is available;
27 (b) The quantity, location, and specialty distribution of health care providers is adequate;
28 and
29 (c) Administrative or clinical protocols do not serve to reduce access to medically
30 necessary treatment for any insured;
31 (4) Coverage for treatment for chemical dependency shall comply with sections 376.779,
32 376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term
33 "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to
34 376.836, the term "health insurance policy" shall include group coverage.
35 2. As used in this section, the following terms mean:
36 (1) "Chemical dependency", the psychological or physiological dependence upon and
37 abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment
38 of social or occupational role functioning or both;
39 (2) "Health benefit plan", the same meaning as such term is defined in section 376.1350;
40 (3) "Health carrier", the same meaning as such term is defined in section 376.1350;
41 (4) "Mental health condition", any condition or disorder defined by categories listed in
42 the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders;
43 (5) "Managed care organization", any financing mechanism or system that manages care
44 delivery for its members or subscribers, including health maintenance organizations and any
45 other similar health care delivery system or organization;
46 (6) "Rate, term, or condition", any lifetime or annual payment limits, deductibles,
47 co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits,
48 and any other financial component of a health benefit plan that affects the insured.
49 3. This section shall not apply to a health plan or policy that is individually underwritten
50 or provides such coverage for specific individuals and members of their families pursuant to
51 section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836, a supplemental
52 insurance policy, including a life care contract, accident-only policy, specified disease policy,
53 hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care
54 policy, hospitalization-surgical care policy, short-term major medical policies **[**~~of six months or~~

55 ~~less duration~~] **having a duration of less than one year**, or any other supplemental policy as
56 determined by the director of the department of insurance, financial institutions and professional
57 registration.

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

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

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

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

68 (3) Care that is custodial in nature;

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

70 (5) Treatments that are considered experimental.

71 6. The director shall grant a policyholder a waiver from the provisions of this section if
72 the policyholder demonstrates to the director by actual experience over any consecutive
73 twenty-four-month period that compliance with this section has increased the cost of the health
74 insurance policy by an amount that results in a two percent increase in premium costs to the
75 policyholder. The director shall promulgate rules establishing a procedure and appropriate
76 standards for making such a demonstration. Any rule or portion of a rule, as that term is defined
77 in section 536.010, that is created under the authority delegated in this section shall become
78 effective only if it complies with and is subject to all of the provisions of chapter 536 and, if
79 applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the
80 powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective
81 date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of
82 rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid
83 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 and
3 management service completed using a secured web-based or similar electronic-based
4 communications network for a single patient encounter. An electronic visit shall be initiated by
5 a patient or by the guardian of a patient with the health care provider, be completed using a
6 federal Health Insurance Portability and Accountability Act (HIPAA)-compliant online
7 connection, and include a permanent record of the electronic visit;

8 (2) "Health benefit plan" shall have the same meaning ascribed to it in section 376.1350;
9 (3) "Health care provider" shall have the same meaning ascribed to it in section
10 376.1350;
11 (4) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief
12 of a physical or mental health condition, illness, injury or disease;
13 (5) "Health carrier" shall have the same meaning ascribed to it in section 376.1350;
14 (6) "Telehealth" shall have the same meaning ascribed to it in section 208.670.
15 2. Each health carrier or health benefit plan that offers or issues health benefit plans
16 which are delivered, issued for delivery, continued, or renewed in this state on or after January
17 1, 2014, shall not deny coverage for a health care service on the basis that the health care service
18 is provided through telehealth if the same service would be covered if provided through
19 face-to-face diagnosis, consultation, or treatment.
20 3. A health carrier may not exclude an otherwise covered health care service from
21 coverage solely because the service is provided through telehealth rather than face-to-face
22 consultation or contact between a health care provider and a patient.
23 4. A health carrier shall not be required to reimburse a telehealth provider or a consulting
24 provider for site origination fees or costs for the provision of telehealth services; however,
25 subject to correct coding, a health carrier shall reimburse a health care provider for the diagnosis,
26 consultation, or treatment of an insured or enrollee when the health care service is delivered
27 through telehealth on the same basis that the health carrier covers the service when it is delivered
28 in person.
29 5. A health care service provided through telehealth shall not be subject to any greater
30 deductible, co-payment, or coinsurance amount than would be applicable if the same health care
31 service was provided through face-to-face diagnosis, consultation, or treatment.
32 6. A health carrier shall not impose upon any person receiving benefits under this section
33 any co-payment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime,
34 or other durational benefit limitation or maximum for benefits or services that is not equally
35 imposed upon all terms and services covered under the policy, contract, or health benefit plan.
36 7. Nothing in this section shall preclude a health carrier from undertaking utilization
37 review to determine the appropriateness of telehealth as a means of delivering a health care
38 service, provided that the determinations shall be made in the same manner as those regarding
39 the same service when it is delivered in person.
40 8. A health carrier or health benefit plan may limit coverage for health care services that
41 are provided through telehealth to health care providers that are in a network approved by the
42 plan or the health carrier.

43 9. Nothing in this section shall be construed to require a health care provider to be
44 physically present with a patient where the patient is located unless the health care provider who
45 is providing health care services by means of telehealth determines that the presence of a health
46 care provider is necessary.
47 10. The provisions of this section shall not apply to a supplemental insurance policy,
48 including a life care contract, accident-only policy, specified disease policy, hospital policy
49 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,
50 short-term major medical policies **[**~~of six months' or less duration~~**]** **having a duration of less**
51 **than one year**, or any other supplemental policy as determined by the director of the department
52 of insurance, financial institutions and professional registration.

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