

SECOND REGULAR SESSION
HOUSE COMMITTEE SUBSTITUTE FOR
SENATE COMMITTEE SUBSTITUTE FOR
SENATE BILL NOS. 1061 & 1062
91ST GENERAL ASSEMBLY

Reported from the Committee on Critical Issues, Consumer Protection and Housing, May 7, 2002, with recommendation that the House Committee Substitute for Senate Committee Substitute for Senate Bill Nos. 1061 & 1062 Do Pass.

TED WEDEL, Chief Clerk

4204L.10C

AN ACT

To repeal sections 354.085, 354.405, 354.603, 376.811, 376.814, 376.825, 376.826, 376.827, 376.830, 376.833, 376.836, and 376.840, RSMo, and to enact in lieu thereof six new sections relating to health insurance administrative simplification.

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

Section A. Sections 354.085, 354.405, 354.603, 376.811, 376.814, 376.825, 376.826,
2 376.827, 376.830, 376.833, 376.836, and 376.840, RSMo, are repealed and six new sections
3 enacted in lieu thereof, to be known as sections 354.085, 354.405, 354.603, 376.811, 376.1450,
4 and 376.1550, to read as follows:

354.085. No corporation subject to the provisions of sections 354.010 to 354.380 shall
2 deliver or issue for delivery in this state a form of membership contract, or any endorsement or
3 rider thereto, until a copy of the form shall have been approved by the director. The director
4 shall not approve any policy forms which are not in compliance with the provisions of sections
5 354.010 to 354.380 of this state, or which contain any provision which is deceptive, ambiguous
6 or misleading, or which do not contain such words, phraseology, conditions and provisions
7 which are specific, certain and reasonably adequate to meet needed requirements for the
8 protection of those insured. If a policy form is disapproved, the reasons therefor shall be stated
9 in writing; a hearing shall be granted upon such disapproval, if so requested; provided, however,
10 that such hearing shall be held no sooner than fifteen days following the request. The failure of
11 the director of insurance to take action approving or disapproving a submitted policy form within

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

12 [thirty] **forty-five** days from the date of filing shall be deemed an approval thereof [until such
13 time as the director of insurance shall notify the submitting company, in writing, of his
14 disapproval]. **The director may not disapprove any deemed policy form for a period of**
15 **twelve months thereafter. If at any time during such twelve-month period the director**
16 **determines that any provision of the deemed policy form is contrary to statute, the director**
17 **shall notify the health services corporation of the specific provision that is contrary to**
18 **statute, and the specific statute to which the provision is contrary to, and may request, if**
19 **the director determines it to be necessary and appropriate, that the health services**
20 **corporation file within thirty days of receipt of the request an amendment form that**
21 **modifies the provision to conform to statute. Upon approval of the amendment form by**
22 **the director, the health services corporation shall issue a copy of the amendment to each**
23 **individual and entity to which the deemed policy form was previously issued and shall**
24 **attach a copy of the amendment to the deemed policy form when it is subsequently issued.**
25 **Such amendment shall have the force and effect as if the amendment was in the original**
26 **filing or policy. If the deemed policy form is a certificate or other form issued to individual**
27 **members, the health services corporation may fulfill its obligation to issue the conforming**
28 **amendment to members to whom the deemed policy form was previously issued by either:**

29 **(1) For group coverage, supplying the group contract holder with a sufficient**
30 **number of copies of the amendment so that the group contract holder may distribute a**
31 **copy to each member to whom the deemed policy form was previously issued; or**

32 **(2) For group or individual coverage, including a copy of the amendment or a**
33 **description of its contents in the health services corporation's next scheduled mailing to**
34 **members.**

35

36 The director of insurance shall have authority to make such reasonable rules and regulations
37 concerning the filing and submission of such policy forms as are necessary, proper or advisable.

354.405. 1. Notwithstanding any law of this state to the contrary, any person may apply
2 to the director for a certificate of authority to establish and operate a health maintenance
3 organization in compliance with this act. No person shall establish or operate a health
4 maintenance organization in this state without obtaining a certificate of authority pursuant to
5 sections 354.400 to 354.636. A foreign corporation may qualify pursuant to sections 354.400
6 to 354.636, subject to its registration to do business in this state as a foreign corporation pursuant
7 to chapter 351, RSMo, and compliance with the provisions of sections 354.400 to 354.636.

8 2. Every health maintenance organization doing business in this state on September 28,
9 1983, shall submit an application for a certificate of authority pursuant to subsection 3 of this
10 section within one hundred twenty days of September 28, 1983. Each such applicant may

11 continue to operate until the director acts upon the application. In the event that an application
12 is not submitted or is denied pursuant to section 354.410, the applicant shall henceforth be
13 treated as a health maintenance organization whose certificate of authority has been revoked.
14 Any health maintenance organization licensed by the department of insurance prior to September
15 28, 1983, and complying with the paid-in capital or guarantee fund requirements of section
16 354.410 shall be issued a certificate of authority upon filing an amended certificate of authority
17 and an amended articles of incorporation that conform with sections 354.400 to 354.636. When
18 the annual statement of a health maintenance organization subject to the provisions of sections
19 354.400 to 354.636 is filed and all fees due from the health maintenance organization are
20 tendered, the health maintenance organization's certificate of authority to do business in this state
21 shall automatically be extended pending formal renewal by the director, or until such time as the
22 director should refuse to renew the certificate.

23 3. Each application for a certificate of authority shall be verified by an officer or
24 authorized representative of the applicant, shall be in a form prescribed by the director, and shall
25 set forth or be accompanied by the following:

26 (1) A copy of the organizational documents of the applicant such as the articles of
27 incorporation, articles of association, partnership agreement, trust agreement, or other applicable
28 documents, and all amendments thereto;

29 (2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating
30 the conduct of the internal affairs of the applicant;

31 (3) A list of the names, addresses, and official positions of the persons who are to be
32 responsible for the conduct of the affairs of the applicant, including all members of the board of
33 directors, board of trustees, executive committee, or other governing board or committee, the
34 principal officers if the applicant is a corporation, and the partners or members if the applicant
35 is a partnership or association;

36 (4) A copy of any contract made or to be made between any providers and persons listed
37 in subdivision (3) of this subsection and the applicant;

38 (5) A copy of the form of evidence of coverage to be issued to the enrollees;

39 (6) A copy of the form of the group contract, if any, which is to be issued to employers,
40 unions, trustees, or other organizations;

41 (7) Financial statements showing the applicant's assets, liabilities, and sources of
42 financial support. If the applicant's financial affairs are audited by independent certified public
43 accountants, a copy of the applicant's most recent certified financial statement shall be deemed
44 to satisfy this requirement unless the director directs that additional or more recent financial
45 information is required for the proper administration of sections 354.400 to 354.636;

46 (8) A description of the proposed method of marketing the plan, a financial plan which

47 includes a three-year projection of operating results anticipated, and a statement as to the sources
48 of working capital as well as any other sources of funding;

49 (9) If the applicant is not domiciled in this state, a power of attorney duly executed by
50 such applicant appointing the director, the director's successors in office, and duly authorized
51 deputies, as the true and lawful attorney of such applicant in and for this state upon whom all
52 lawful process in any legal action or proceeding against the health maintenance organization on
53 a cause of action arising in this state may be served;

54 (10) A statement reasonably describing the geographic area or areas to be served;

55 (11) A description of the complaints procedures to be utilized as required by section
56 354.445;

57 (12) A description of the mechanism by which enrollees will be afforded an opportunity
58 to participate in matters of policy and operation;

59 (13) Evidence demonstrating that the health maintenance organization has provided its
60 enrollees with adequate access to health care providers; and

61 (14) Such other information as the director may require to make the determinations
62 required in section 354.410.

63 4. Every health maintenance organization shall file with the director notice of its
64 intention to modify any of the procedures or information described in and required to be filed by
65 this section. Such changes shall be filed with the director prior to the actual modification. **If a**
66 **filing that is a document described in subdivision (4), (5), or (6) of subsection 3 of this**
67 **section is disapproved, the reasons therefor shall be stated in writing and a hearing shall**
68 **be granted upon such disapproval if so requested; provided that such hearing shall be held**
69 **no sooner than fifteen days following the request.** If the director does not **approve or**
70 disapprove the modification within [thirty] **forty-five** days of filing, such modification shall be
71 deemed approved. **If a filing that is deemed approved is a document described in**
72 **subdivision (4), (5) or (6) of subsection 3 of this section, the director may not disapprove**
73 **the deemed filing for a period of twelve months thereafter. If at any time during that**
74 **twelve-month period the director determines that any provision of the deemed filing is**
75 **contrary to statute, the director shall notify the health maintenance organization of the**
76 **specific provision that is contrary to statute, and the specific statute to which the provision**
77 **is contrary to, and may request, if the director determines it to be necessary and**
78 **appropriate, that the health maintenance organization file within thirty days of receipt of**
79 **the request an amendment form that modifies the provision to conform to the state statute.**
80 **Upon approval of the amendment form by the director, the health maintenance**
81 **organization shall issue a copy of the amendment to each individual and entity to which the**
82 **deemed filing was previously issued and shall attach a copy of the amendment to the**

83 **deemed filing when it is subsequently issued. Such amendment shall have the force and**
84 **effect as if the amendment was in the original filing or policy. If the deemed policy form**
85 **is an evidence of coverage or other form issued to individual enrollees, the health**
86 **maintenance organization may fulfill its obligation to issue the conforming amendment to**
87 **enrollees to whom the deemed policy form was previously issued by either:**

88 **(1) For group coverage, supplying the group contract holder with a sufficient**
89 **number of copies of the amendment so that the group contract holder may distribute a**
90 **copy to each enrollee to whom the deemed policy form was previously issued; or**

91 **(2) For group or individual coverage, including a copy of the amendment or a**
92 **description of its contents in the health maintenance organization's next scheduled mailing**
93 **to enrollees.**

94 5. A health maintenance organization shall file all contracts of reinsurance. Any
95 agreement between the organization and an insurer shall be subject to the laws of this state
96 regarding reinsurance. All reinsurance agreements and any modifications thereto shall be filed
97 and approved.

98 6. When the director deems it appropriate, the director may exempt any item from the
99 filing requirements of this section.

354.603. 1. A health carrier shall maintain a network that is sufficient in number and
2 types of providers to assure that all services to enrollees shall be accessible without unreasonable
3 delay. In the case of emergency services, enrollees shall have access twenty-four hours per day,
4 seven days per week. The health carrier's medical director shall be responsible for the
5 sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by
6 the director in accordance with the requirements of this section and by reference to any
7 reasonable criteria, including but not limited to, provider-enrollee ratios by specialty, primary
8 care provider-enrollee ratios, geographic accessibility, reasonable distance accessibility criteria
9 for pharmacy and other services, waiting times for appointments with participating providers,
10 hours of operation, and the volume of technological and specialty services available to serve the
11 needs of enrollees requiring technologically advanced or specialty care.

12 (1) In any case where the health carrier has an insufficient number or type of
13 participating providers to provide a covered benefit, the health carrier shall ensure that the
14 enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a
15 participating provider, or shall make other arrangements acceptable to the director.

16 (2) The health carrier shall establish and maintain adequate arrangements to ensure
17 reasonable proximity of participating providers, including local pharmacists, to the business or
18 personal residence of enrollees. In determining whether a health carrier has complied with this
19 provision, the director shall give due consideration to the relative availability of health care

20 providers in the service area under, especially rural areas, consideration.

21 (3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and
22 legal authority of its providers to furnish all contracted benefits to enrollees. The provisions of
23 this subdivision shall not be construed to require any health care provider to submit copies of
24 such health care provider's income tax returns to a health carrier. A health carrier may require
25 a health care provider to obtain audited financial statements if such health care provider received
26 ten percent or more of the total medical expenditures made by the health carrier.

27 (4) A health carrier shall make its entire network available to all enrollees unless a
28 contract holder has agreed in writing to a different or reduced network.

29 2. A health carrier shall file with the director, in a manner and form defined by rule of
30 the department of insurance, an access plan meeting the requirements of sections 354.600 to
31 354.636 for each of the managed care plans that the health carrier offers in this state. The health
32 carrier may request the director to deem sections of the access plan as proprietary or competitive
33 information that shall not be made public. For the purposes of this section, information is
34 proprietary or competitive if revealing the information will cause the health carrier's competitors
35 to obtain valuable business information. The health carrier shall provide such plans, absent any
36 information deemed by the director to be proprietary, to any interested party upon request. The
37 health carrier shall prepare an access plan prior to offering a new managed care plan, and shall
38 update an existing access plan whenever it makes any change as defined by the director to an
39 existing managed care plan. The director shall approve or disapprove the access plan, or any
40 subsequent alterations to the access plan, within sixty days of filing. The access plan shall
41 describe or contain at a minimum the following:

42 (1) The health carrier's network;

43 (2) The health carrier's procedures for making referrals within and outside its network;

44 (3) The health carrier's process for monitoring and assuring on an ongoing basis the
45 sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

46 (4) The health carrier's methods for assessing the health care needs of enrollees and their
47 satisfaction with services;

48 (5) The health carrier's method of informing enrollees of the plan's services and features,
49 including but not limited to, the plan's grievance procedures, its process for choosing and
50 changing providers, and its procedures for providing and approving emergency and specialty
51 care;

52 (6) The health carrier's system for ensuring the coordination and continuity of care for
53 enrollees referred to specialty physicians, for enrollees using ancillary services, including social
54 services and other community resources, and for ensuring appropriate discharge planning;

55 (7) The health carrier's process for enabling enrollees to change primary care

56 professionals;

57 (8) The health carrier's proposed plan for providing continuity of care in the event of
58 contract termination between the health carrier and any of its participating providers, in the event
59 of a reduction in service area or in the event of the health carrier's insolvency or other inability
60 to continue operations. The description shall explain how enrollees shall be notified of the
61 contract termination, reduction in service area or the health carrier's insolvency or other
62 modification or cessation of operations, and transferred to other health care professionals in a
63 timely manner; and

64 (9) Any other information required by the director to determine compliance with the
65 provisions of sections 354.600 to 354.636.

66 **3. In reviewing an access plan filed pursuant to subsection 2 of this section, the**
67 **director shall deem a managed care plan's network to be adequate if, in lieu of the network**
68 **information required by subdivision (1) of subsection 2 of this section, the health carrier**
69 **submits a sworn affidavit signed by an officer of the health carrier stating that it meets one**
70 **or more of the following criteria:**

71 (1) **The managed care plan is a Medicare + Choice coordinated care plan offered**
72 **by the health carrier pursuant to a contract with the Federal Centers for Medicare and**
73 **Medicaid Services;**

74 (2) **The managed care plan is being offered by a health carrier that has been**
75 **accredited by the National Committee for Quality Assurance at a level of "accredited" or**
76 **better, and such accreditation is in effect at the time the access plan is filed; or**

77 (3) **The managed care plan's network has been accredited by the Joint Commission**
78 **on the Accreditation of Health Organizations at a level of "accreditation without type I**
79 **recommendations" or better, and such accreditation is in effect at the time the access plan**
80 **is filed. If the accreditation applies to only a portion of the managed care plan's network,**
81 **only the accredited portion will be deemed adequate.**

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

17 (5) The coverages set forth in this subsection shall be:

18 (a) Subject to the same coinsurance, co-payment and deductible factors as apply to
19 physical illness;

20 (b) Administered pursuant to a managed care program established by the insurance
21 company or health services corporation; and

22 (c) Covered services may be delivered through a system of contractual arrangements
23 with one or more providers, hospitals, nonresidential or residential treatment programs, or other
24 mental health service delivery entities certified by the department of mental health, or accredited
25 by a nationally recognized organization, or licensed by the state of Missouri.

26 2. [In addition to the coverages set forth in subsection 1 of this section, every insurance
27 company, health services corporation and health maintenance organization doing business in this
28 state shall offer in all health insurance policies, benefits or coverages for recognized mental
29 illness, excluding chemical dependency, meeting the following minimum standards:

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

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

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

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

42 (5) The coverages set forth in this subsection may be administered pursuant to a
43 managed care program established by the insurance company, health services corporation or
44 health maintenance organization, and covered services may be delivered through a system of
45 contractual arrangements with one or more providers, community mental health centers,
46 hospitals, nonresidential or residential treatment programs, or other mental health service

47 delivery entities certified by the department of mental health, or accredited by a nationally
48 recognized organization, or licensed by the state of Missouri.

49 3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the
50 group or individual policyholder or contract holder and, if accepted, shall fully and completely
51 satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to
52 376.814 shall prohibit an insurance company, health services corporation or health maintenance
53 organization from including all or part of the coverages set forth in sections 376.810 to 376.814
54 as standard coverage in their policies or contracts issued in this state.

55 4.] Every insurance company, health services corporation and health maintenance
56 organization doing business in this state shall offer in all health insurance policies mental health
57 benefits or coverage as part of the policy or as a supplement to the policy. Such mental health
58 benefits or coverage shall include at least two sessions per year to a licensed psychiatrist,
59 licensed psychologist, licensed professional counselor, or licensed clinical social worker acting
60 within the scope of such license and under the following minimum standards:

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

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

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

69 [5.] 3. If the group or individual policyholder or contract holder rejects the offer required
70 by this section, then the coverage shall be governed by [the mental health and chemical
71 dependency insurance act as provided in sections 376.825 to 376.835] **section 376.779.**

**376.1450. An enrollee, as defined in section 376.1350, may waive his or her right to
2 receive documents and materials from a managed care entity in printed form so long as
3 such documents and materials are readily accessible electronically through the entity's
4 Internet site. An enrollee may revoke such waiver at any time by notifying the managed
5 care entity by phone or in writing. Any enrollee who does not execute such a waiver and
6 prospective enrollees shall have documents and materials from the managed care entity
7 provided in printed form. For purposes of this section, "managed care entity" includes,
8 but is not limited to, a health maintenance organization, preferred provider organization,
9 point of service organization, and any other managed health care delivery entity of any
10 type or description.**

376.1550. 1. Notwithstanding any other provision of law to the contrary, each

2 health carrier that offers or issues health benefit plans which are delivered, issued for
3 delivery, continued, or renewed in this state on or after January 1, 2003, shall provide
4 coverage for a mental health condition, as defined in this section, and shall comply with the
5 following 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
8 burden on an insured for access to treatment for a mental health condition than for access
9 to treatment for a physical health condition. Any deductible or out-of-pocket limits
10 required by a health carrier or health benefit plan shall be comprehensive for coverage of
11 all health conditions, whether mental or physical;

12 (2) A health benefit plan that does not otherwise provide for management of care
13 under the plan or that does not provide for the same degree of management of care for all
14 health conditions may provide coverage for treatment of mental health conditions through
15 a managed care organization; provided that the managed care organization assures that
16 the system for delivery of treatment for mental health conditions does not diminish or
17 negate the purpose of this section; and

18 (3) A health benefit plan shall be construed to be in compliance with this section
19 if at least one choice for treatment of mental health conditions provided to the insured
20 within the plan has rates, terms, and conditions that place no greater financial burden on
21 the insured than for access to treatment of physical conditions.

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

23 (1) "Health benefit plan", the same meaning as such term is defined in section
24 376.1350;

25 (2) "Health carrier", the same meaning as such term is defined in section 376.1350;

26 (3) "Mental health condition", any condition or disorder, except chemical
27 dependence, defined by categories listed in the most recent edition of the Diagnostic and
28 Statistical Manual of Mental Disorders;

29 (4) "Managed care organization", any financing mechanism or system that
30 manages care delivery for its members or subscribers, including health maintenance
31 organizations and any other similar health care delivery system or organization;

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

35 3. This section shall not apply to a supplemental insurance policy, including a life
36 care contract, accident-only policy, specified disease policy, hospital policy providing a
37 fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term

38 **major medical policies of six months or less duration, or any other supplemental policy as**
39 **determined by the director of the department of insurance.**

2 [376.814. 1. The department of insurance shall promulgate rules and
3 regulations, pursuant to section 376.982 and chapter 536, RSMo, and the department
4 of mental health shall advise the department of insurance on the promulgation of said
5 rules and regulations as they pertain to the development and implementation of all
6 standards and guidelines for managed care as set out in sections 376.810 to 376.814,
7 to ensure that all mental health services provided pursuant to sections 376.810 to
8 376.814 are provided in accordance with chapters 197, 334, 337, RSMo, and section
9 630.655, RSMo, provided however, that nothing in this act shall prohibit department
10 of mental health licensed or certified facilities or programs from using qualified
11 mental health professionals or other specialty staff persons.

12 2. Any person who serves or served on a quality assessment and assurance
13 committee required under 42 U.S.C. Sec. 1396r(b)(1)(B) and 42 CFR Sec. 483.75(r),
14 or as amended, shall be immune from civil liability only for acts done directly as a
15 member of such committee so long as the acts are performed in good faith, without
16 malice and are required by the activities of such committee as defined in 42 CFR Sec.
483.75(r).]

2 [376.825. Sections 376.825 to 376.840 shall be known and may be cited as
the "Mental Health and Chemical Dependency Insurance Act".]

2 [376.826. For the purposes of sections 376.825 to 376.840 the following
terms shall mean:

- 3 (1) "Director", the director of the department of insurance;
- 4 (2) "Health insurance policy" or "policy", all group health insurance policies
5 providing coverage on an expense-incurred basis, all group service or indemnity
6 contracts issued by a not for profit health services corporation, all self-insured group
7 health benefit plans of any type or description to the extent that regulation of such
8 plans is not preempted by federal law, and all such health insurance policies or
9 contracts that are individually underwritten or provide such coverage for specific
10 individuals and members of their families as nongroup policies, which provide for
11 hospital treatments. The term shall also include any group or individual contract
12 issued by a health maintenance organization. The provisions of sections 376.825 to
13 376.840 shall not apply to policies which provide coverage for a specified disease
14 only, other than for mental illness or chemical dependency;
- 15 (3) "Insurer", an entity licensed by the department of insurance to offer a
16 health insurance policy;
- 17 (4) "Mental illness", the following disorders contained in the International
18 Classification of Diseases (ICD-9-CM):
 - 19 (a) Schizophrenic disorders and paranoid states (295 and 297, except 297.3);
 - 20 (b) Major depression, bipolar disorder, and other affective psychoses (296);
 - 21 (c) Obsessive compulsive disorder, post-traumatic stress disorder and other
22 major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81);
 - 23 (d) Early childhood psychoses, and other disorders first diagnosed in

24 childhood or adolescence (299.8, 312.8, 313.81 and 314);
25 (e) Alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); and
26 (f) Anorexia nervosa, bulimia and other severe eating disorders (307.1,
27 307.51, 307.52 and 307.53);
28 (g) Senile organic psychotic conditions (290);
29 (5) "Rate", "term", or "condition", any lifetime limits, annual payment limits,
30 episodic limits, inpatient or outpatient service limits, and out-of-pocket limits. This
31 definition does not include deductibles, co-payments, or coinsurance prior to
32 reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy
33 shall be comprehensive for coverage of mental illness and physical conditions.]

[376.827. 1. Nothing in this bill shall be construed as requiring the coverage
2 of mental illness.

3 2. Except for the coverage required pursuant to subsection 1 of section
4 376.779, and the offer of coverage required pursuant to sections 376.810 through
5 376.814, if any of the mental illness disorders enumerated in subdivision (4) of
6 section 376.826 are provided by the health insurance policy, the coverage provided
7 shall include all the disorders enumerated in subdivision (4) of section 376.826 and
8 shall not establish any rate, term, or condition that places a greater financial burden
9 on an insured for access to evaluation and treatment for mental illness than for access
10 to evaluation and treatment for physical conditions, generally, except that alcohol and
11 other drug abuse services shall have a minimum of thirty days total inpatient
12 treatment and a minimum of twenty total visits for outpatient treatment for each year
13 of coverage. A lifetime limit equal to four times such annual limits may be imposed.
14 The days allowed for inpatient treatment can be converted for use for outpatient
15 treatment on a two-for-one basis.

16 3. Deductibles, co-payment or coinsurance amounts for access to evaluation
17 and treatment for mental illness shall not be unreasonable in relation to the cost of
18 services provided.

19 4. A health insurance policy that is a federally qualified plan of benefits shall
20 be construed to be in compliance with sections 376.825 to 376.836 if the policy is
21 issued by a federally qualified health maintenance organization and the federally
22 qualified health maintenance organization offered mental health coverage as required
23 by sections 376.825 to 376.836. If such coverage is rejected, the federally qualified
24 health maintenance organization shall, at a minimum, provide coverage for mental
25 health services as a basic health service as required by the Federal Public Health
26 Service Act, 42 U.S.C. Section 300e., et seq.

27 5. Health insurance policies that provide mental illness benefits pursuant to
28 sections 376.825 to 376.840 shall be deemed to be in compliance with the
29 requirements of subsection 1 of section 376.779.

30 6. The director may disapprove any policy that the director determines to be
31 inconsistent with the purposes of this section.]

[376.830. 1. The coverages set forth in sections 376.825 to 376.840 may be
2 administered pursuant to a managed care program established by the insurance

3 company, health services corporation or health maintenance organization, and
4 covered services may be delivered through a system of contractual arrangements with
5 one or more licensed providers, community mental health centers, hospitals,
6 nonresidential or residential treatment programs, or other mental health service
7 delivery entities certified by the department of mental health, or accredited by a
8 nationally recognized organization, or licensed by the state of Missouri. Nothing in
9 this section shall authorize any unlicensed provider to provide covered services.

10 2. An insurer may use a case management program for mental illness benefits
11 to evaluate and determine medically necessary and clinically appropriate care and
12 treatment for each patient.

13 3. Nothing in sections 376.825 to 376.840 shall be construed to require a
14 managed care plan as defined by section 354.600, RSMo, when providing coverage
15 for benefits governed by sections 376.825 to 376.840, to cover services rendered by
16 a provider other than a participating provider, except for the coverage pursuant to
17 subsection 4 of section 376.811. An insurer may contract for benefits provided in
18 sections 376.825 to 376.840 with a managing entity or group of providers for the
19 management and delivery of services for benefits governed by sections 376.825 to
20 376.840.]

2 [376.833. 1. The provisions of section 376.827 shall not be violated if the
insurer decides to apply different limits or exclude entirely from coverage the
3 following:

- 4 (1) Marital, family, educational, or training services unless medically
5 necessary and clinically appropriate;
- 6 (2) Services rendered or billed by a school or halfway house;
- 7 (3) Care that is custodial in nature;
- 8 (4) Services and supplies that are not medically necessary nor clinically
9 appropriate; or
- 10 (5) Treatments that are considered experimental.

11 2. The director shall grant a policyholder a waiver from the provisions of
12 section 376.827 if the policyholder demonstrates to the director by actual experience
13 over any consecutive twenty-four-month period that compliance with sections
14 376.825 to 376.840 has increased the cost of the health insurance policy by an
15 amount that results in a two percent increase in premium costs to the policyholder.]

2 [376.836. 1. The provisions of sections 376.825 to 376.840 apply to
applications for coverage made on or after January 1, 2000, and to health insurance
3 policies issued or renewed on or after such date to residents of this state. Multiyear
4 group policies need not comply until the expiration of their current multiyear term
5 unless the policyholder elects to comply before that time.

6 2. The director shall perform a study to assess the impact of the mental health
7 and substance abuse insurance act on insurers, business interests, providers, and
8 consumers of mental health and substance abuse treatment services. The director
9 shall report the findings of this study to the general assembly by January 1, 2004.]

2 [376.840. Notwithstanding the provision of subsection 1 of section 376.827,
3 all health insurance policies which cover state employees including the Missouri
4 consolidated health care plan shall include coverage for mental illness. Multiyear
5 group policies need not comply until the expiration of their current multiyear term
unless the policyholder elects to comply before that time.]