HCS SS SB 262 -- HEALTH INSURANCE

SPONSOR: Curls (Molendorp)

COMMITTEE ACTION: Voted "Do Pass" by the Committee on Health Insurance by a vote of 7 to 4.

This substitute changes the laws regarding health insurance. In its main provision, the substitute:

(1) Allows a physician, when establishing a physician-patient relationship, to perform a physical examination of a patient either in person or via telehealth;

(2) Specifies that the powers of a health maintenance organization (HMO) include offering at least one health benefit plan that contains deductibles combined with a health savings or health reimbursement account meeting specified conditions, coinsurance, coinsurance differentials, or variable copayments;

(3) Requires that a statement or summary of evidence of coverage include any limitations on the services, kinds of services, benefits or kinds of benefits to be provided, including coinsurance or other cost sharing features as requested by the group contract holder or, in the case of non-group coverage, the individual certified holder;

(4) Allows a health carrier to offer a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services and certain chemical dependency treatments, and requires this provision to be disclosed in the policy form;

(5) Authorizes the Director of the Department of Insurance, Financial Institution and Professional Registration to make rules and regulations concerning the filing and submission of policies, including the disapproval of policies. If a policy form is disapproved, all specific reasons for noncompliance must be stated in writing within 45 days of the date of filing, and the director must approve or disapprove a submitted policy within 45 days of the date of filing or the policy will be considered approved. However if the director deems any provision of the policy is contrary to state law, the director must notify the carrier of the provision and request the carrier file an amendment to modify it. The amended policy cannot be retroactively enforced if the health carrier files the amendment form within 30 days of the request from the department;

(6) Specifies that beginning August 28, 2013, the Board of

Directors, the Executive Director, and any employees of the Missouri Health Insurance Pool will have the authority to provide assistance or resources to the federal government for the specific purpose of transitioning individuals enrolled in the pool to coverage outside of the pool on or before January 1, 2014. This authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange. By September 1, 2013, the board must submit the amendments to the plan of operation as are necessary or suitable to ensure a reasonable transition period to allow for the termination of issuance of policies by the pool. The amendments must include all current requirements under Section 376.962.2, RSMo, including the selection of an administering insurer or third-party administrator, and must address the transition of individuals covered under the pool to alternative health insurance coverage as it is available after January 1, 2014. The plan of operation must also address procedures for finalizing the financial matters of the pool, including assessments, claims expenses, and other specified matters. The Director of the Department of Insurance, Financial Institutions and Professional Registration must review the plan of operation and must establish rules to effectuate the transitional plan of operation. The rules must be effective no later than October 1, 2013;

(7) Specifies that prior to January 1, 2014, the board of directors and administering insurers may issue policies of insurance from the Missouri Health Insurance Pool; however, they are prohibited from issuing new insurance policies on or after January 1, 2014. All coverage under the pool must expire on January 1, 2014;

(8) Requires, by September 1, 2013, the board to invite all insurers and third-party administrators, including the current administering insurer, to submit bids to serve as the administering insurer or third-party administrator for the pool. The selection of the administering insurer or third-party administrator must be made prior to January 1, 2014. Beginning January 1, 2014, the administering insurer or third-party administrator must:

(a) Submit to the board and the department director a detailed plan outlining the winding down of operations of the pool. The plan must be submitted no later than January 31, 2014, and must be updated quarterly thereafter;

(b) Perform all administrative claim-payment functions relating to the pool;

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including making

information on submitting a claim for benefits to the pool available, distributing forms on which submissions must be made, and evaluating the eligibility of each claim for payment by the pool;

(d) Submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report must be determined by the board;

(e) Determine, following the close of each calendar year, the expense of administration and the paid and incurred losses for the year and report the information to the board and department on a form prescribed by the department director; and

(f) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services;

(9) Requires Missouri Health Insurance Pool assessments to continue until the executive director of the pool notifies the board and the department director that all claims have been paid. Any assessment funds remaining at the time that all claims have been paid must be deposited in the General Revenue Fund;

(10) Requires, beginning September 1, 2013, the Oversight Division of the Joint Committee on Legislative Research to conduct an actuarial analysis of the cost impact to consumers, health insurers, and other private and public payers if state mandates were enacted to provide health benefit plan coverages for the following:

(a) Orally administered anticancer medication at the same copayment or deductible as intravenously administered or injected cancer medication; and

(b) Diagnosis and treatment of eating disorders, including residential treatment and access to psychiatric and medical treatments;

(11) Requires the division director to submit a report of the actuarial findings to the Speaker of the House of Representatives, President Pro Tem of the Senate, and the chair of the House Special Committee on Health Insurance and the Senate Small Business, Insurance and Industry Committee by December 31, 2013. The analysis must assume that the mandated coverage will not be subject to any greater deductible or copayment than other health care services provided under a health benefit plan and will not apply to a supplemental insurance policy. The cost for each actuarial analysis cannot exceed $30,000;

(12) Prohibits a contract between a health carrier or health benefit plan and a dentist from requiring the dentist to provide services to an insured at a fee established by the carrier or plan if the services are not covered under the plan;

(13) Requires, beginning January 1, 2014, a health carrier that offers or issues plans that provide coverage for prescription eye drops to provide coverage for refilling the eye drop prescription prior to the last day of the insured's dosage period as long as the prescribing health care provider authorizes the early refill and the health carrier or health benefit plan is notified. Coverage must not be subject to any greater deductible or copayment than other similar health care services provided by the health plan. The substitute exempts specified supplemental insurance policies from these provisions;

(14) Allows a health carrier to electronically contact enrollees and providers acting on behalf of enrollees in the case of a determination or adverse determination to certify an admission, procedure, service, extended stay, or additional services;

(15) Requires every health carrier that credentials health care professionals in a health benefit plan to provide a practitioner access to the carrier's Internet web portal within 48 hours after receiving an electronic credentialing application to verify the receipt of the practitioner's application. A health carrier must assess the practitioner's credentialing information and decide to approve or deny the application within 90 days of receipt of the completed application. The deadline must not apply if the application or subsequent verification information indicates the practitioner has: a history of behavioral disorders or other impairments affecting the ability to practice, including substance abuse; any disciplinary actions against his or her license imposed by any state, territory, or foreign jurisdiction; his or her hospital admitting or surgical privileges or other credentials or authority to practice revoked, restricted, or suspended based on clinical performance; or a judgment or judicial award arising from a medical malpractice liability lawsuit. The department must establish a mechanism for reporting alleged violations of these provisions to the department; and

(16) Prohibits health carriers issuing or renewing health benefit plans on or after January 1, 2014, from denying coverage for a health care service on the basis that the service was provided through telehealth if the same service would be covered when delivered in person. A health carrier may not exclude an otherwise covered health care service from coverage solely because the service is provided through telehealth rather than face-to-face consultation or contact between a health care provider and a

patient. Subject to approval by the health carrier, health care services may be provided by telehealth providers without any prior face-to-face consultation or contact between a health care provider and a patient. A health carrier is not required to reimburse a telehealth provider or a consulting provider for site origination fees or costs of telehealth services. However, subject to correct coding, a health carrier must reimburse a telehealth provider for the diagnosis, consultation, or treatment of an insured delivered through telehealth on the same basis that the health carrier covers the service when it is delivered in person. A health care service provided through telehealth services must not be subject to any greater deductible, copayment, or coinsurance amount than would be applicable if the same health care service was provided through face-to-face diagnosis, consultation, or treatment. Health carriers may undertake utilization review to determine the appropriateness of telehealth as a means of delivering a health care service. However, utilization review determinations must be made in the same manner as those regarding the same service when it is delivered in person. A health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier.

The provisions regarding telehealth services has an effective date of January 1, 2014.

The provisions regarding the actuarial analysis will expire December 31, 2013.

The provisions regarding prescription eye drops will expire January 1, 2017.

PROPONENTS: Supporters say that the bill prohibits health carriers from excluding normally covered health services because the services were provided via telemedicine. The bill is appropriate and timely in the current health care climate and helps bedridden patients who will receive access to a health professional at any time via video. The bill covers a wide range of patient services, including evisits, monitoring, emergency services, and family counseling. It makes sense to give health plan members as much access to health care as is possible. The biggest benefit is the ability to provide access to specialists for patients in rural areas of Missouri.

Testifying for the bill were Senator Curls; Anthem Blue Cross Blue Shield of Missouri; United Healthcare Services, Inc.; Cerner; Dr. Todd Whitt, University of Missouri Health System; St. Louis Chidren's Hospital; Missouri Psychiatric Society; Missouri Association of Osteopathic Physicians and Surgeons; St. Luke Health

System; Center for Diagnostic Imaging; Missouri Dermatological Society ; and Bridget McCandless, Missouri State Medical Association.

OPPONENTS: There was no opposition voiced to the committee.