Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (19), (28), (35), (46), (47), and (70).

PURPOSE: This rule establishes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.

PURPOSE: This amendment revises the definitions of diabetes education, essential benefits, Health Savings Account Plan, network, and non-network; and removes the definition of terminated vested subscriber because it is duplicative of section (73); and renumbers as necessary.

(1) Accident. An unforeseen and unavoidable event resulting in an injury.

(2) Active employee. A benefit-eligible person employed by a public entity who meets the plan eligibility requirements.

(3) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

(4) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, and plan changes.

(5) Adverse benefit determination. An adverse benefit determination means any of the following:
(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;
(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or
(C) Rescission of coverage after an individual has been covered under the plan.

(6) Allowed amount. Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed (see balance billing, section (8)).

(7) Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

(8) Balance billing. When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars ($100) and the allowed amount is seventy dollars ($70), the provider may bill the member for the remaining thirty dollars ($30). A network provider may not balance bill.

(9) Benefits. Health care services covered by the plan.

(10) Board. The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

(11) Cancellation of coverage. The ending of medical, dental, or vision coverage per a subscriber's voluntary request.

(12) Claims administrator. An organization or group responsible for processing claims and associated services for a health plan.

(13) Coinsurance. The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars ($100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars ($20). The health insurance or plan pays the rest of the allowed amount.

(14) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

(15) Copayment. A fixed amount, for example, fifteen dollars ($15), the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.

(16) Date of service. Date medical services are received.

(17) Deductible. The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars ($1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollar ($1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

(18) Dependent. Spouse or child(ren) enrolled in the plan by a subscriber.

(19) Diabetes *[education]* **Self-Management Education/Training**. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

(20) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental medicine, including dental surgery;
(H) Doctor of dentistry; or

(I) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

(21) Effective date. The date on which coverage takes effect.

(22) Eligibility date. The first day a member is qualified to enroll for coverage.

(23) Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.

(24) Emergency medical condition. The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(A) Placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) With respect to a pregnant woman who is having contractions—

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

(25) Emergency services. With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

(26) Employee. A benefit-eligible person employed by a participating public entity, including present and future retirees from the participating public entity, who meet the plan eligibility requirements.

(27) Employer. The public entity that employs the eligible employee.

(28) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance use disorder services, including behavioral health treatment—inpatient and outpatient and mental health/substance use disorder office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care;

(H) Laboratory services—lab and X-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, *[immunizations]***vaccinations**, preventive services, and newborn screenings.

(29) Excluded drug. A drug the pharmacy benefit manager (PBM) does not pay for or cover unless an exception is approved by the PBM.

(30) Excluded services. Health care services that the member's health plan does not pay for or cover.

(31) Experimental/investigational/unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan—

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis; or

(C) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

(32) Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager (PBM) and covered by the plan administrator. The PBM categorizes each formulary drug and formulary supply as preferred or non-preferred.

(33) Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

(34) Health savings account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA.

(35) *[Health Savings Account (HSA) Plan]***High deductible Health Plan**. A health plan with a higher deductible than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

(36) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered an illness.

(37) Incident. A definite and separate occurrence of a condition.

(38) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

(39) Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.

(40) Long-term disability subscriber. A subscriber eligible for long-term disability coverage through a public entity's retirement system.

(41) MCHCPid. An individual MCHCP subscriber identifier used for member verification and validation.

(42) myMCHCP. A secure MCHCP member website that allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, retrieve and send secure messages, upload documents, and access health plan websites.

(43) Medically necessary. The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary treatments, procedures, services, or supplies that the plan administrator or its designee determines, in the exercise of its discretion are—

(A) Expected to be of clear clinical benefit to the member;

(B) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms;

(C) In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;

(D) Not primarily for member or provider convenience; and

(E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms.

(44) Medicare-allowed amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a health care provider.

(45) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

(46) Network. The *[facilities,]* providers*[, and suppliers]* the health insurer or plan has contracted with to provide health care services **to members**.

(47) Non-network. Non-network. The *[facilities,]* providers*, [and suppliers]* the *[health plan]***health insurer, or plan** does not contract with to provide health care services **to members**. **Some providers may be a part of secondary provider networks recognized by the vendor for non-network benefits.**

(48) Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, balance-billed charges, or health care services the plan does not cover.

(49) Participant. Shall have the same meaning as the term member defined herein (see member, section (45)).

(50) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

(51) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.

(52) Plan year. The period of January 1 through December 31.

(53) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

(54) Premium. The monthly amount that must be paid for health insurance.

(55) Primary care provider (PCP). An internist, family/general practitioner, pediatrician, or physician assistant or nurse practitioner in any of the practice areas listed in this definition.

(56) Preauthorization. A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. The plan may require preauthorization for certain services before the member receives them, except in an emergency. Preauthorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request preauthorization.

(57) Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(21). Other providers include, but are not limited to:

(A) Audiologist (AUD or PhD);
(B) Certified Addiction Counselor for Substance Abuse (CAC);
(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;
(D) Certified Social Worker or Masters in Social Work (MSW);
(E) Chiropractor;
(F) Licensed Clinical Social Worker (LCSW);
(G) Licensed Professional Counselor (LPC);
(H) Licensed Psychologist (LP);
(I) Nurse Practitioner (NP);
(J) Physician Assistant (PA);
(K) Occupational Therapist;
(L) Physical Therapist;
(M) Speech Therapist;
(N) Registered Nurse Anesthetist (CRNA);
(O) Registered Nurse Practitioner (ARNP); or
(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

(58) Prudent layperson. An individual possessing an average knowledge of health and medicine.

(59) Public entity. A political subdivision or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.

(60) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.

(61) Retiree. Notwithstanding any provision of law to the contrary, for the purposes of these regulations, a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from an entity-sponsored retirement system.

(62) Sound, natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound, natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

(63) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

(64) Specialty medications. High-cost drugs, as determined by the pharmacy benefit manager and/or third party administrator which treat chronic or complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

(65) State. Missouri.

(66) Step therapy. Therapy designed to encourage use of therapeutically equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

(67) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the member and recover the money directly from the other insurer.

(68) Subscriber. The person who elects coverage under the plan.

(69) Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree of a public entity with a retirement system.

[(70) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit through a public entity's retirement system.]

*[(71)]***(70)** Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

*[(72)]***(71)** Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

*[(73)]***(72)** Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

*[(74)]***(73)** Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits through a public entity's retirement system.

*[(75)]***(74)** Waiting/probationary periods. The length of time the employer requires an employee to be employed before he or she is eligible for health insurance coverage. Public entities may set different waiting/probationary periods for different employee classifications (full-time vs. part-time).

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated March 7, 2011. Emergency amendment filed Feb. 25, 2011, effective March 7, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expired June 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Amended: Filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expired June 29, 2015. Amended: Filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expired June 28, 2016. Amended: Filed Oct. 28, 2015, effective May 30, 2016. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expired June 29, 2017. Amended: Filed Oct. 28, 2016, effective May 30, 2017. Emergency amendment filed Oct. 30, 2018, effective Jan. 1, 2019, expires June 29, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

**Original authority: 103.059, RSMo 1992.*