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

PROPOSED AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (3), (6), (8), (10), and (12).

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, Plan Benefit Provisions, and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This amendment revises the HSA Plan deductible, out-of-pocket maximum and clarifies influenza vaccinations, diabetes self-management education/training, family deductible, access to payment information, and maximum plan payments.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars ($1,650); family, three thousand three hundred dollars ($3,300) and for non-network: per individual, *[four thousand dollars ($4,000)]* **three thousand three hundred dollars ($3,300);** family, *[eight thousand dollars ($8,000)]* **six thousand six hundred dollars ($6,600)**.

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered family member. Once the family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(E) Medical and pharmacy expenses are combined to apply toward the network or non-network deductible amount, as appropriate.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—*[three thousand three hundred dollars ($3,300)]* **four thousand nine hundred fifty dollars ($4,950)**;

2. Network out-of-pocket maximum for family—*[six thousand six hundred dollars ($6,600)]* **nine thousand nine hundred dollars ($9,900). Any individual family member need only incur a maximum of seven thousand nine hundred dollars ($7,900) before the plan begins paying one hundred percent (100%) of covered charges for that individual**;

3. Non-network out-of-pocket maximum for individual—*[five thousand dollars ($5,000)]* **nine thousand nine hundred dollars ($9,900)**; and

4. Non-network out-of-pocket maximum for family—*[ten thousand dollars ($10,000)]* **nineteen thousand eight hundred dollars ($19,800)**.

(B) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed.

(D) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) Preventive care is not subject to deductible or coinsurance requirements and will be paid at one hundred percent (100%) when provided by a network provider.

(6) Influenza*[immunizations]***vaccinations** provided by a non-network provider will be reimbursed up to twenty-five dollars ($25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Nutritional counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(8) Four (4) diabetes *[education]***self-management education/training** visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

(9) Newborn's claims will be subject to deductible and coinsurance.

(10) Each subscriber will have access to payment information of the family unit **only when authorization is granted by the adult covered dependent(s)**.

(11) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

(12) *[Usual, customary, and reasonable fee allowed]***Maximum plan payment**—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at *[the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor]* **one hundred ten percent (110%) of Medicare reimbursement**. Members may be held liable for the amount of the fee above the allowed amount.

(13) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(15) A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (16) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare (unless Medicare is secondary coverage to MCHCP);

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-purpose health FSA, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

(16) A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

(17) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. 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 rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expired June 28, 2016. Rescinded and readopted: 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 and 103.080, RSMo 2007, amended 2011.*