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

PROPOSED RULE

22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1250 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, one thousand two hundred fifty dollars ($1,250); family, two thousand five hundred dollars ($2,500) and for non-network: per individual, two thousand five hundred dollars ($2,500); family, five thousand dollars ($5,000).

(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 is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall 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.

(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 Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.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—per calendar year for network: per individual, three thousand seven hundred fifty dollars ($3,750); family, seven thousand five hundred dollars ($7,500) and for non-network: per individual, seven thousand five hundred dollars ($7,500); family, fifteen thousand dollars ($15,000).

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

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: 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.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(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; and

(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) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza 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) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager systems, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled, the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

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

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

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars ($25); mental health: twenty-five dollars ($25); specialist: forty dollars ($40); chiropractor office visit and/or manipulation: the lesser of twenty dollars ($20) or fifty percent (50%) of the total cost of services; urgent care: fifty dollars ($50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—two hundred fifty dollars ($250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(C) Inpatient hospitalization—two hundred dollars ($200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) 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.

(13) 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 copayment, deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. 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.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Oct. 30, 2018.

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

PRIVATE COST: This proposed rule 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 rule 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.*