Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED AMENDMENT

22 CSR 10-2.010 Definitions. The board is amending section (1).

PURPOSE: This amendment includes changes in the definitions made by the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.

(1) When used in this plan document, these words and phrases have the meaning—

(HH) Plan document—This statement of the terms and conditions of the plan *[revised and effective January 1, 1995,]* as adopted by the plan administrator;

(MM) Prior plan—The terms and conditions of a plan in effect for *[a]* **the** period preceding *[January 1, 1995]* **coverage in the MCHCP**;

(PP) Review agency—A company responsible for administration of *[the four (4) components of the Health Check program under the direction of the claims administrator]* **clinical management programs**;

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. Amended: Filed Dec. 6, 1999.*

PUBLIC COST: This proposed amendment is estimated to cost state agencies and political subdivisions less than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $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, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED AMENDMENT

22 CSR 10-2.020 Membership Agreement and Participation Period. The board is amending sections (1), (3) and (4) and removing forms that follow the rule from the *Code of State Regulations*.

PURPOSE: The amendment includes changes and clarifications made by the board of trustees regarding the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

(1) The application packet and confirmation notice shall comprise the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under the MCHCP a public entity agrees that—

1. For groups of less than five hundred (500) employees, the MCHCP will be the only health care offering made to its eligible members. For groups of five hundred (500) or more employees the entity may maintain a self-insured indemnity plan or one point-of-service (POS) option (either self-insured or on a fully-insured directly contracted basis), but may not offer a competing plan of the same type through the MCHCP **(also see paragraph (1)(A)8.)**;

2. It will contribute at least twenty-five dollars ($25) per month toward each active employee's premium;

3. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining one of the indemnity options. Appropriate proof of said deductibles will be required;

4. Eligible members joining the MCHCP who were covered by any medical plan offered by the public entity or an individual policy will not be subject to any pre-existing condition;

5. Eligible members joining the MCHCP at the time of the initial eligibility of the public entity will not have to prove insurability;

6. For groups contracting only with the MCHCP, at least seventy-five percent (75%) of all eligible employees must join the MCHCP. For groups of five hundred (500) employees or more that choose one (1) of the alternative options identified in paragraph (1)(A)1., the entity must maintain seventy-five percent (75%) coverage of all their employees covered through all of their offerings;

7. An eligible employee is one that is not covered by another group sponsored plan;

8. *[Public entities joining the plan will be able to select whatever plans they wish from those available through the MCHCP to be offered to their eligible members]* **Public entities joining the MCHCP must allow their eligible subscribers the option of choosing the managed health care plans that are available through the MCHCP that are licensed in a county in which the subscriber either lives or works**;

9. Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees in consideration of section (6); and

10. A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective.

(3) The participation period shall begin on the participant's effective date in the plan. Participation shall continue until this plan or coverage in this rule is terminated for any reason. However, transfer from the prior plan to this plan will be automatic upon the effective date of this plan *[, except that any participant confined to a hospital on the effective date of this plan shall be continued under the prior plan until discharged from the hospital]*.

(4) The effective date of participation shall be determined, subject to the effective date provision in subsection (4)(C), as follows:

(B) Dependent Coverage. Dependent participation cannot precede the employee's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once an employee is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. The employee is required to notify the plan administrator on the

appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided—

1. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

2. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; and

3. Unless required under federal guideline—

A. An emancipated dependent who regains his/her dependent status is not eligible for coverage until the next open enrollment period; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period**. (Note: Subparagraphs (4)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan)**;

(C) Effective Date *Proviso*.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity*[.]***;**

[2. If any dependent, other than a newborn child, is confined in a hospital on the date participation with respect to dependent coverage would otherwise become effective, participation shall become effective on the day after the date of discharge from the hospital; and]

(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren). **Application must be made within sixty (60) days of the court order.** (Note: This section does not include dependents of retirees or long-term disability recipients covered under the plan*[.]*)**; and**

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. Amended: filed Dec. 6, 1999.*

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PRIVATE COST: This proposed amendement will not cost private entities more than $500 in the aggregate.

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Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED AMENDMENT

22 CSR 10-2.040 Indemnity Plan Summary of Medical Benefits. The board is amending sections (1), (3), (4), (7) and (9).

PURPOSE: This amendment includes changes made by the board of trustees regarding medical benefits for participants in the Missouri Consolidated Health Care Plan.

(1) Lifetime maximum, *[one (1)]* **three (3)** million dollars.

(3) Deductible Amount—Per individual for the indemnity plan *[and the limited indemnity plan]* each calendar year, three hundred dollars ($300), family limit each calendar year, nine hundred dollars ($900).

(4) *[Copayment]* **Coinsurance**.

(C) *[Limited Indemnity Plan]* **Non-Network Services—**Same as subsections (4)(A) and (B), except covered charges are reimbursed on a seventy percent (70%) basis.

(7) *[Health Check]* **Clinical Management**—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(9) Prescription Drug Program—The indemnity plan provides *[a carve-out program for prescription drugs. The program consists of]* coverage for maintenance and nonmaintenance medications, as described in the following:

[(A) Nonmaintenance Medications—For those prescription drugs needed for short-term use only, the member will be responsible for twenty percent (20%) of a discounted rate after satisfaction of the twenty-five dollar ($25) individual deductible (seventy-five dollars ($75) maximum family deductible).

1. The prescription must be written for less than a thirty (30)-day supply.

2. If the member chooses a brand name medication when there is a generic available, s/he will be responsible for twenty percent (20%) of the generic medication's cost (after satisfaction of the deductible), as well as the difference between the cost of the brand name medication and the generic medication. This difference does not apply to the out-of-pocket maximum. This provision does not apply if the doctor has indicated on the prescription that the brand name is necessary.

(B) Maintenance Medications—For those medications listed on the maintenance medication list, as determined by the claims administrator, the member will be responsible for a fifteen-dollar ($15) copayment for each brand name medication and a five-dollar ($5) copayment for each generic medication.

1. The prescription must be written for a thirty to ninety (30–90)-day supply.

2. Maintenance medications may be purchased from either a participating local pharmacy or the mail order facility.

3. Unless an exception is approved by the drug/claims administrator for a medically necessary reason, oral contraceptives must be obtained from an approved formulary list.

(C) Out-of-Pocket Maximum—There is a maximum out-of-pocket (including deductibles) of four hundred dollars ($400) per individual, with a maximum family out-of-pocket of twelve hundred dollars ($1200). The out-of-pocket maximum applies to both maintenance and nonmaintenance medications. Once a member has reached the four hundred dollar ($400)-maximum his/her covered drugs will be covered at 100% for the remainder of the calendar year.]

(A) Nonmaintenance Medications.

1. In-Network.

A. $5 Copay for 30-day supply for generic drug on the formulary.

B. $10 Copay for 30-day supply for brand drug on the formulary.

C. $15 Copay for 30-day supply for non-formulary drug.

2. Non-network. The deductible will apply. After satisfaction of the deductible, claims will be paid at fifty-percent (50%) coinsurance. Charges will not be applied to the out-of-pocket maximum.

(B) Maintenance Medications. Prescriptions may be filled through a mail order program for up to a ninety (90)-day supply for twice the regular copayment for a drug on the maintenance list.

[(D)] **(C)** Nonparticipating Pharmacies*[—]***.** If a member chooses to use a nonparticipating pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at a participating pharmacy, less any applicable deductibles or coinsurance. Any difference between the amount paid by the member at a nonparticipating pharmacy and the amount that would have been allowed at a participating pharmacy will not be applied to the out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. Amended: Filed Dec. 6, 1999.*

PUBLIC COST: This proposed amendment is estimated to cost state agencies or political subdivisions less than $500 in the aggregate.

PRIVATE COST: There is a potential for some individual members to incur additional costs in excess of $500 due to the changes in some of the covered benefits and/or the copayment levels. These could be either state members or individuals enrolled through the public entities. Please see attached fiscal note for estimated cost.

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, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE ENTITY COST

V. RULE NUMBER

Title: 22 – Missouri Consolidated Health Care Plan

Chapter: Chapter 10

Type of Rulemaking: Proposed Amendment to Rule

Rule Number and Name: 2.040 Indemnity Plan Summary of Medical Benefits

VI. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Percentage using pharmacy of the 3,759 members	Individuals enrolled in the MCHCP in the PPO	$504,000

VII. WORKSHEET

The cost for pharmacy in the health benefit plan has been increasing at a far greater rate than any other benefit. Consequently, the plan design for many programs is being modified to counter an increase in the cost and utilization in this area.

The MCHCP will be implementing a three-tiered benefit design. Under this arrangement, the member will pay the following:

$5 for a generic prescription on the formulary
$15 for a brand prescription on the formulary
$25 for a non-formulary drug

If a non-network pharmacy is utilized, the deductible will apply, claims will be paid at 50% coinsurance and the charges will not be applied to the out-of-pocket maximum.

The current design calls for a separate $25 deductible, 20% coinsurance and a $400 out-of-pocket maximum. Drugs obtained at non-network pharmacies are paid at the network level.

VIII. ASSUMPTIONS

It is estimated that the change in coverage for this benefit will be approximately 4.8% of the total premium. Consequently, it is anticipated that, on average, each member would pay approximately an additional $134 per year. This is an estimated annual total cost of $504,466.

However, some of this cost could be offset by the savings incurred by the increase in the allowable lifetime maximum and/or the increased coverage in the mental health/substance abuse benefit.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED AMENDMENT

22 CSR 10-2.050 Indemnity Plan Benefit Provisions and Covered Charges. The board is amending subsection (2)(C).

PURPOSE: The amendment includes changes made by the board of trustees regarding benefit provisions and covered charges in the Missouri Consolidated Health Care Plan.

(2) Covered Charges.

(C) Covered charges are divided into mutually exclusive types and each covered charge shall be deemed to be covered on the date the medical benefit, service or supply is received.

1. Type A charges for hospital daily room and board and routine nursing. The maximum covered charge for a private room is the hospital's most common semiprivate room rate unless a private room is recommended by a physician and approved by the claims administrator or the plan's medical review agency.

2. Type B charges for intensive care, concentrated care, coronary care or other special hospital unit designed to provide special care for critically ill or injured patients.

3. Type C charges for preadmission testing (X-ray and laboratory tests) which are conducted and which are necessary for hospital admission and which are not duplicated for screening purposes upon admission to the hospital.

4. Type D special hospital charges for inpatient medical care and supplies received during any period room and board charges are made except—

A. Those included in paragraphs (2)(C)1.–3.; and

B. Special nursing care.

5. Type E charges for outpatient medical care or supplies.

6. Type F surgery and anesthesia charges of a provider for the giving of anesthesia not included in paragraphs (2)(C)4. and 5.

7. Type G psychiatric service charges of a provider licensed to provide services which relate to care of mental conditions.

8. Type H professional service charges not included in paragraphs (2)(C)2.–7. made by a provider or by a laboratory for diagnostic laboratory and X-ray exams.

9. Type I nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) on his/her own behalf.

10. Type J professional service charges of a licensed physical therapist, occupational therapist, audiologist or respiratory therapist, subject to medical necessity review by claims administrator.

11. Type K transportation charges not included in paragraphs (2)(C)3. and 4. for professional air or ground ambulance services for local transportation to and from a hospital, from a hospital to and from a local facility which provides specialized testing or treatment or from a hospital to a skilled nursing facility; and charges for travel within the United States by a scheduled railroad, airline or ambulatory carrier to, but not back from, the nearest hospital equipped to furnish needed special treatment.

12. Type L charges for orthopedic or prosthetic devices and hospital-type equipment not included in paragraphs (2)(C)4. and 5. for—

A. Man-made limbs or eyes for the replacing of natural limbs or eyes;

B. Casts, splints or crutches;

C. Purchase of a truss or brace as a direct result of—

(I) An injury or sickness which began while covered under these rules; or

(II) A disabling condition existing since birth;

D. Oxygen and rental of equipment for giving oxygen; rental of wheelchair **or scooter (manual or powered)** or hospital equipment to aid in breathing;

E. Dialysis equipment rental, supplies, upkeep and the training of the participant or an attendant to run the equipment; *[and]*

F. Colostomy bags and ureterostomy bags*[.]***;**

G. Bilateral hearing aids; and

H. Augmentative communication devices.

13. Type M charges for prescription drugs from a licensed pharmacist or for anesthesia when given by a provider if not included in paragraphs (2)(C)3.–6.

14. Type N charges for skilled nursing care including room and board when the stay is medically necessary, as determined by the claims administrator.

15. Type O charges for the services of a licensed speech therapist if the charges are made for speech therapy used for the purpose of correcting speech loss or damage which—

A. Is due to a sickness or injury, other than a functional nervous disorder or surgery due to such sickness or injury; or

B. Follows surgery to correct a birth defect.

16. Type P charges for services and supplies from a home health care agency which are medically necessary, as determined by the claims administrator.

17. Type Q charges for outpatient treatment of mental and nervous conditions.

18. Type R charges for outpatient treatment of alcohol and drug abuse.

19. Type S charges for hospice services.

20. Type T charges for education and training if it will promote the patient to a lower level of medical/nursing care.

21. Type U charges for surgical and medical procedures performed by a podiatrist.

22. Type V charges for transplants.

23. Type W charges for services rendered by a physician or other provider.

24. Type Y charges for normally covered services arising from a noncovered service.

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. Amended: Filed Dec. 6, 1999.*

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Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED AMENDMENT

22 CSR 10-2.060 Indemnity Plan Limitations. The board is amending section (1).

PURPOSE: This amendment includes changes made by the board of trustees regarding limitations for participants in the Missouri Consolidated Health Care Plan Indemnity Plan.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services or supplies which do not come within the definition of covered charges, or any of the following:

(C) Cosmetic, plastic, reconstructive or restorative surgery performed for the purpose of improving appearance unless such expenses are incurred for repair of a disfigurement caused from any of the following:

1. An accidental injury which was sustained while covered under these rules;

2. A sickness first manifested while covered under these rules;

3. Any other accidental injury or sickness but only for expenses incurred after this coverage has been in force for at least *[twelve (12)]* **six (6)** months; or

4. A birth defect;

(D) Hearing aids **once every two (2) years** and the fitting, eye refractions and glasses, contact lenses or their fitting of eye glasses or contact lenses (other than the first pair of contact lenses or eye glasses or the fitting after cataract surgery which is performed while covered under these rules);

(H) *[To the extent provided by law, intentionally self-inflicted injury or illness, or i]***I**njury or sickness resulting from taking part in the commission of a felony;

(M) Except as may otherwise be specifically provided, expenses for equipment, services or supplies for any of the following, regardless of whether or not prescribed by a physician or provider:

1. Experimental/investigational procedures, as defined in the claims administrator's guidelines;

2. Exercise for the eyes;

3. Psychological testing;

4. Nerve stimulators with the exception of transcutaneous electrical nerve stimulator (TENS) units;

5. Any treatment of obesity due solely to overeating;

6. Custodial care;

7. *[In vitro and i]**In vivo* artificial insemination **including gamete intrafallopian transfer/zygote intrafallopian transfer (GIFT/ZIFT)**;

8. Travel **(see subsection (1)(EE))**, lodging **(see subsection (1)(EE))**, recreation or exercise;

9. Air conditioners, purifiers or humidifiers;

10. Nonprescription drug items (except insulin and other diabetic supplies); and

11. Acupuncture, acupressure, and biofeedback;

(R) *[Alcohol]* **Outpatient alcohol** and drug abuse treatments are limited to*—[two (2) inpatient treatments per lifetime, the copayment does not apply to the out-of-pocket maximum and there is a lifetime maximum of fifty thousand dollars ($50,000).*

1. Network provider—up to thirty (30) days per calendar year paid at ninety percent (90%). In addition to three hundred dollar ($300)-medical deductible, there is also a one hundred dollar ($100) per day deductible for up to five (5) days.

2. Non-network provider—up to thirty (30) days per calendar year paid at seventy percent (70%). In addition to three hundred dollar ($300)-medical deductible, there is also a one hundred fifty dollar ($150)-deductible for up to five (5) days;]

1. Network provider.

A. First five (5) visits paid with a ten-dollar ($10) copayment.

B. Visit six (6) through ten (10) with a fifteen-dollar ($15) copayment.

C. Additional visits paid with a twenty-dollar ($20) copayment.

2. Non-network provider.

A. Subject to deductible and fifty percent (50%) coinsurance;

[(S) Inpatient mental illness services are limited to thirty (30) days per year, and the copayment does not apply to the out-of-pocket maximum.

1. Network provider—paid at ninety percent (90%).

2. Non-network provider—paid at seventy percent (70%).

3. Partial day treatment—included acute day treatment and partial hospitalization. Treated as one-half (1/2) inpatient day toward thirty (30)-day maximum.

A. Network provider—paid at ninety percent (90%).

B. Non-network provider—paid at seventy percent (70%);]

[(T)] **(S)** Outpatient mental illness services are limited to*—[fifty (50) visits per year. The copayment does not apply to the out-of-pocket maximum.]*

1. Network provider.

A. First five (5) visits paid *[at ninety percent (90%)]* **with a ten-dollar ($10) copayment**.

B. Visit six (6) through *[twenty (20) paid at seventy percent (70%)]* **ten (10) with a fifteen-dollar ($15) copayment**.

C. *[Visit twenty-one through fifty (21–50) paid at fifty percent (50%).]* **Additional visits paid with a twenty-dollar ($20) copayment**.

2. Non-network provider.

A. *[First five (5) visits paid at seventy percent (70%).*

B. Visit six through twenty (6-20) paid at fifty percent (50%).

C. Visit twenty-one through fifty (21–50) paid at fifty percent (50%).] **Subject to deductible and fifty percent (50%) coinsurance;**

[3. Intensive outpatient services.

A. Network provider paid at ninety percent (90%).

B. Non-network provider paid at seventy percent (70%);]

[(U)] **(T)** Marital and family counseling for group or individual psychotherapy;

[(V)] **(U)** Chiropractic services are limited to a maximum allowable charge of fifty dollars ($50) per visit, and a two thousand-dollar ($2,000) total annual maximum. Diagnostic lab and X-ray services are not included in fifty-dollar ($50) maximum per visit, but are included in two thousand-dollar ($2,000) total annual maximum;

[(W)] **(V)** Associated charges for noncovered services;

[(X)] **(W)** Any services not specifically included as a covered benefit;

[(Y)] **(X)** Vitamins and nutrient supplements, except prescription prenatal vitamins, vitamin B_{12} shots, and certain vitamin therapies as determined by the claims administrator;

[(Z)] **(Y)** Treatment of temporal mandibular joint dysfunction (TMJ) will be covered under the plan up to maximum reimbursement of five hundred dollars ($500) per lifetime;

[(AA)] **(Z)** Reversals of tubal ligations and vasectomies;

[(BB) Cardiac rehabilitation treatments are limited to thirty-six (36) visits per calendar year;]

[(CC)] **(AA)** X-ray and office charges associated with flat feet;

[(DD)] **(BB)** Preferred Provider Organization (PPO) office visit copayments; *[and]*

[(EE)] **(CC)** Transplants are limited to heart, lung, liver, kidney, cornea**,** *[and]* bone marrow, **pancreas and intestinal,** and are subject to medical necessity and effectiveness criteria and payment levels as determined by the claims administrator's guidelines *[. Benefits are limited to one hundred fifty thousand dollars ($150,000) for services associated with the admission of the actual organ transplant with remainder of transplant cost applied to one (1) million dollar lifetime maximum.]***;**

Benefits are allowed in accordance with the following schedule:

Benefit Description	The First Health National Transplant Program	First Health Network (PPO) Hospital	Non-PPO Hospital	Additional Limitations and Explanations
Plan Pays	**100%**	**90% of NTP fees**	**70%* of NTP fees**	**Travel, lodging and meals allowance is for the transplant recipient and his or her immediate family travel companion (under age 19, both parents). The plan's copayment will be reduced by 10% when not using The First Health National Transplant Program if you do not follow the procedures required by the clinical management services program. This penalty and your non-PPO coinsurance do not apply to the out-of-pocket maximum.**
Annual Deductible	**NO**	**YES**	**YES**	
Organ Donor Costs Per Transplant	**Unlimited**	**$10,000**	**$10,000**	
Travel, Lodging and Meals Allowance Per Transplant	**$10,000**	**None**	**None**	
Lifetime benefit Maximum	**Subject to Plan Maximum**	**Subject to Plan Maximum**	**Subject to Plan Maximum**	

[(FF)] **(DD)** Skilled nursing charges limited to one hundred twenty (120) days per calendar year*[.]*;

(EE) *In vivo* artificial insemination subject to deductible and fifty percent (50%) coinsurance, which does not apply to the out-of-pocket maximum. Not covered out-of-network;

(FF) Eye refractions limited to one (1) annually and only if provided in the network; and

(GG) Treatment of nearsightedness, farsightedness and astigmatism.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expiredAug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. Amended: Filed Dec. 6, 1999.*

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Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED AMENDMENT

22 CSR 10-2.063 HMO/POS/POS98 Summary of Medical Benefits. The board is amending subsection (1)(Z).

PURPOSE: This amendment includes changes made by the board of trustees regarding the medical benefits of the HMO/POS and POS98 plans in the Missouri Consolidated Health Care Plan Indemnity Plan.

(1) Covered Charges.

(Z) Prescription Drugs—*[Maximum thirty (30)-day supply, five dollar ($5) copayment]*. Insulin, syringes, test strips and glucometers are included in this coverage. *[Additional restrictions may apply for use of nonformulary medication with HMO/POS. POS98 lessor of twenty dollar ($20) copayment or cost of drug for nonformulary drug.]* **There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable copayment or the cost of the drug.**

1. Five-dollar ($5) copay for thirty (30)-day supply for generic drug on the formulary.

2. Ten-dollar ($10) copay for thirty (30)-day supply for brand drug on the formulary.

3. Fifteen-dollar ($15) copay for thirty (30)-day supply for nonformulary drug.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. Amended: Filed Dec. 6, 1999.*

PUBLIC COST: This proposed amendment is estimated to cost state agencies or political subdivisions less than $500 in the aggregate.

PRIVATE COST: There is a potential for some individual members to incur additional costs in excess of $500 due to the changes in some of the covered benefits and/or the copayment levels. These could be either state members or individuals enrolled through the public entities. Please see attached fiscal note for estimated cost.

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, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 22 – Missouri Consolidated Health Care Plan

Chapter: Chapter 10

Type of Rulemaking: Proposed Amendment to Rule

Rule Number and Name: 2.063 HMO/POS/POS98 Summary of Medical Benefits

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Percentage using pharmacy of the 104,714 members	Individuals enrolled in the MCHCP in an HMO/POS	$8.34 million

III. WORKSHEET

The cost for pharmacy in the health benefit plan has been increasing at a far greater rate than any other benefit. Consequently, the plan design for many programs is being modified to counter an increase in the cost and utilization in this area.

The MCHCP will be implementing a three-tiered benefit design. Under this arrangement, the member will pay the following:

$5 for a generic prescription on the formulary
$15 for a brand prescription on the formulary
$25 for a non-formulary drug

The current design is $5 for any drug on the formulary. The benefit for non-formulary drugs varies by plan.

IV. ASSUMPTIONS

It is estimated that the change in coverage for this benefit will be approximately 4.8% of the total premium. Consequently, it is anticipated that, on average, each member would pay approximately an additional $80 per year. This is an estimated annual total cost of $8.34 million.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The board is amending subsection (5)(D).

PURPOSE: This amendment includes changes made by the board of trustees regarding the review and appeals procedure for participants in the Missouri Consolidated Health Care Plan.

(5) All insured members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the HMO, POS or Indemnity health plan contract applicable to the insured member. Only after these procedures have been exhausted may the insured appeal to the MCHCP board of trustees to review the decision of the health plan contractor.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either an insured member or health plan contractor.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.

4. In reviewing these appeals, the board and/or staff may consider—

A. Newborns.

(I) Notwithstanding any other rule, if a member currently has children coverage under the plan, s/he may enroll his/her newborn retroactively to the date of birth if the request is made within six (6) months of the child's date of birth. If a member does not currently have children coverage under the plan but states that the required information was provided within the thirty-one (31)-day enrollment period, s/he must sign an affidavit stating that their information was provided within the required time period. The affidavit must be notarized and received in the MCHCP office within thirty-one (31) days after the date of notification from the MCHCP.

(II) Once the MCHCP receives the signed affidavit from the member, coverage for the newborn will be backdated to the date of birth, if the request was made within six (6) months of the child's date of birth. The approval notification will include language that the MCHCP has no contractual authority to require the contractors to pay for claims that are denied due to the retroactive effective date. If an enrollment request is made under either of these two (2) scenarios past six (6) months following a child's date of birth, the information will be forwarded to the MCHCP board for a decision.

B. Credible evidence. Notwithstanding any other rule, the MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office or the MCHCP, that was no fault of the member.

C. Change of plans due to dependent change of address. A member may change plans outside the open enrollment period if his/her covered dependents move out of state and their current plan cannot provide coverage.

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. Amended: Filed Dec. 6, 1999.*

PUBLIC COST: This proposed amendment is estimated to cost state agencies or political subdivisions less than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $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, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*