

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 1—Improper or Unfair Claims Settlement
Practices**

ORDER OF RULEMAKING

By the authority vested in the Department of Insurance, Financial Institutions and Professional Registration under sections 375.045 and 376.1007, RSMo 2000 and sections 376.383 and 376.384, RSMo Supp. 2007, the director adopts a rule as follows.

20 CSR 100-1.070 is adopted.

A notice of the proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2008 (33 MoReg 1879 – 1881). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing on this proposed rule was held November 18, 2008, and the public comment period ended November 25, 2008. At the public hearing, department staff explained the new rule and the director received comments from National Counsel for Prescription Drug Programs (NCPDP), Express Scripts, Medco Health Solutions, Inc. (Medco), and America's Health Insurance Plans (AHIP)

COMMENT #1: National Counsel for Prescription Drug Programs (NCPDP), Express Scripts, and Medco Health Solutions, Inc. (Medco) all commented with concerns regarding the proposed regulation's application to prescription drug cards. NCPDP commented that it has established a standard format for prescription drug cards as well as for combination cards that include both prescription and medical services coverage. Although the proposed rule does not directly affect pharmacy cards, NCPDP expressed concern that the rule may result in confusion and extra expense across a broad spectrum of the industry's members if these cards must be altered to comply with the proposed rule. Express Scripts expressed a similar concern that requiring pharmacy or prescription drug cards to comply with this proposed rule and deviate from the standards already established by the NCPDP would raise administrative costs for pharmacy benefit managers, its clients, and ultimately consumers. Express Scripts stated that pharmacy benefit managers (PBM) rarely re-issue cards, and that the information being required on the cards, according to this rule, may not be available or necessary to the PBM in administering the pharmacy benefit. As such, Express Scripts requested that the director amend the proposed rule to require pharmacy benefit cards to be issued with language consistent with the NCPDP guidelines. Medco also recommended that the director adopt the established standards for prescription drug program identification cards set forth and described in the NCPDP guidelines. Because most, if not all of the states use the NCPDP standard identification card, requiring changes to the information only on cards issued in Missouri would put an undue financial burden on national companies that participate in the Missouri pharmacy benefit market place.

RESPONSE: Based on the information presented by NCPDP and contained in its Health Care Identification Card – Pharmacy and/or Combination ID Card Implementation Guide, the rule will be modified to exempt from its requirements identification cards that relate solely to the provision of prescription drug benefits.

COMMENT #2: America's Health Insurance Plans (AHIP), commented that it is working with the Council for Affordable Quality Healthcare (CAQH) and other stakeholders in the health care system on a national level on a planned proof of concept that would provide uniform web

portal(s) where providers can interface to a critical mass of health plans in an effort to promote quality interactions between plans, providers, and other stakeholders and to reduce costs and frustrations associated with healthcare delivery and administration. As such, AHIP encourages the director to take into account its work being done with respect to simplifying access to patient eligibility and benefit information through the CAQH and its partnership with key provider organizations. AHIP expressed concern as to whether the proposed rule would achieve the intended goals and whether it would result in increased costs, in that health carriers would be required to produce and issue millions of redesigned identification cards. AHIP expressed concern that the cost of this redesign and reissuance of cards would ultimately increase the cost of healthcare for consumers. It also requested clarification regarding the impetus and statutory authority for the proposed regulation and offered to enter into dialogue with the director to determine whether there are more cost-effective and efficient alternatives to achieve the director's objectives. Based on these reasons, AHIP requests that the director withdraw this proposed regulation.

RESPONSE: The director appreciates the comments and concerns raised by AHIP. It is the director's understanding that similar requirements for health carriers' identification cards exist in other states. As such, health carriers are already bound by the requirement that some information be included on the identification cards indicating whether the plan is a self-funded plan or whether it is a plan regulated by the state department of insurance. Furthermore, the intent of subsection (3)(C) of the rule was to give health carriers approximately one (1) year to modify their systems before they would be required to issue identification cards in compliance with the rule. The director will modify subsection (3)(C) to help clarify this issue. In response AHIP's question of statutory authority, §376.384.6, RSMo, requires the director to develop a method by which health care providers may submit complaints to the department relating to carriers' practices which may violate the provisions of §§376.383 and 376.384, RSMo. The director, pursuant to §376.384.8, RSMo, also has authority to promulgate rules for the implementation of those laws. Furthermore, §§376.936(6) and 375.1007(1), RSMo, require health carriers to accurately represent to its insureds the benefits, advantages, conditions, or terms of any policy and to provide relevant facts or policy provisions relating to coverages at issue. The purpose of this rule is to implement those laws by providing a means by which the provider can readily identify whether the acts of the carrier fall under the jurisdiction of the department. For further clarification, the term "DOI" in 20 CSR 100-1.070(3)(A)3. will be changed to indicate "fully insured."

20 CSR 100-1.070 Identification Cards Issued by Health Carriers

(1) Applicability.

(A) This rule applies to all health carriers offering or providing a plan of health insurance, health benefits, or health services to individuals and groups.

(B) The provisions of this rule shall not apply to identification cards issued to individuals or groups that relate solely to the provision of prescription drug benefits.

(2) Definitions. As used in this section—

(A) "Health benefit plan" shall mean health benefit plan as defined in section 376.1350(18), RSMo; and

(B) "Health carrier" shall mean health carrier as defined in section 376.1350(22), RSMo.

(3) Identification Cards.

(A) An identification card or similar document issued to insureds or enrollees shall include the following information:

1. The name of the enrollee or insured;

2. The first date on which the enrollee or insured became eligible for benefits under the plan or a toll-free number that a health care provider may use to obtain such information; and

3. Indicate that the health benefit plan offered by the health carrier is regulated by the Department of Insurance, Financial Institutions and Professional Regulation by placing "Fully Insured" on the front.

(B) Nothing shall prohibit the issuer of a health benefit plan from using an identification card containing a magnetic strip or other technological component enabling the electronic transmission of information, provided that the information required in this section is printed on the card.

(C) The requirements of this section shall apply as follows:

1. Beginning on March 1, 2010, for all new health benefit plans issued on or after March 1, 2010; and
2. On the first plan anniversary after March 1, 2010, for all health benefit plans already in effect on March 1, 2010.