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

EMERGENCY AMENDMENT

22 CSR 10-3.055 *[Health Savings Account] HSA 1800* Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending the title, purpose statement, subsection (3)(A), sections (14) and (19), and renumbering as necessary.

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the [Health Savings Account (HSA)] **HSA 1800** Plan, Plan Benefit Provisions, and Covered Charges of the Missouri Consolidated Health Care Plan.*

PURPOSE: This amendment revises the name of the HSA Plan to the HSA 1800 Plan, the amount an individual family member enrolled in a family plan need only incur before plan begins paying one hundred percent (100%) of covered charges for the individual, and adds the deductible roll up option for families.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2027, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, will be published in the December 15, 2026, issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 16, 2026 becomes effective January 1, 2027 and expires June 29, 2027.*

(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 – five thousand four hundred dollars ($5,400);

2. Network out-of-pocket maximum for family – ten thousand eight hundred dollars ($10,800). Any individual family member need only incur a maximum of eight thousand *[five]* **seven** hundred dollars *[($8,500)]* **($8,700)** before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual – nine thousand nine hundred dollars ($9,900); and

4. Non-network out-of-pocket maximum for family – nineteen thousand eight hundred dollars ($19,800).

(14) 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 system, 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.

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

*[(15)]***(16)** 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.

*[(16)]***(17)** Non-network plan payment – Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed following the claims administrator's practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

*[(17)]***(18)** Any claim must be initially submitted within twelve (12) months following the date of service, unless otherwise specified in the network provider contract. 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 time frame 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.

*[(18)]***(19)** 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.

*[(19)]***(20)** A subscriber does not qualify for the HSA **1800** Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (*[20]***21**) 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:

*[(20)]***(21)** 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.

*[(21)]***(22)** 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 determined by the claims administrator. 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. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Nov. 16, 2026, effective Jan. 1, 2027, expires June 29, 2027. An emergency and a proposed amendment covering this same material will be published in the December 15, 2026, issue of the* ***Missouri Register****.*

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

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is in effect.