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SENATE SUBSTITUTE

FOR

SENATE COMMITTEE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 1742

AN ACT

To repeal sections 208.151 and 208.640, RSMo, and to enact in lieu thereof five new sections relating to health care, with an emergency clause, and an expiration date.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 208.151 and 208.640, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 191.006, 191.990, 208.146, 208.151, and 208.640, to read as follows:

191.006. 1. There is established a permanent joint committee of the general assembly to be known as the "Joint Committee on Health" which shall be composed of five members of the senate and five members of the house of representatives. No major party shall be represented on the committee by more than three members from the senate nor by more than three members from the house. The speaker of the house of representatives and the president pro tem of the senate shall appoint the respective majority members. The minority leader of the house and the minority leader of the senate shall appoint the respective

minority members. A majority of the members of the committee shall constitute a quorum. The members annually shall select one of the members to be the chair and one of the members to be the vice chair. The members shall receive no additional compensation, but shall be reimbursed for actual and necessary expenses incurred by them in the performance of their duties. The committee is authorized to meet and act year round and to employ the necessary personnel within the limits of appropriations. The staff of the committee on legislative research, house research, and senate research shall provide necessary clerical, research, fiscal, and legal services to the committee, as the committee may request.

2. The duties of the committee shall include, but not be limited to:

(1) Analyzing and developing policy proposals to reach the goal of all citizens of the state having affordable healthcare available to them;

(2) Monitoring the design and implementation of any initiatives proposed by the Medicaid reform commission in the areas of:

(a) Wellness, prevention, and responsibility;

(b) Health care provider and patient satisfaction;

(c) Coordinated care;

(d) Technology;

(e) Mental health;

(f) Long-term care;

(g) Pharmacy;

(h) Availability of quality care;

(i) Eligibility;

(3) Analyzing and developing policy proposals to improve the delivery of healthcare services in Missouri;

(4) Monitoring the evolving needs, costs, solutions, and problems surrounding the area of health care policy;

(5) Reporting, as the committee deems fit, to the general assembly any recommended legislative action;

(6) Issuing findings to the departments, commissions, and offices, when appropriate, of any recommended administrative or procedural changes.

3. All state departments, commissions, and offices responsible for the administration of health care policies, mental health, and social services shall cooperate with and assist the committee in the performance of its duties and shall make available all books, records, and information requested, except individually identifiable information regarding a specific patient. The committee may also consult with public and private universities and academies, public and private organizations, and private citizens in the performance of its duties. The committee may contract with public and private entities, within the limits of appropriation, for analysis and study of current or proposed changes to health care policy. The committee shall have the power to subpoena witnesses, take testimony under oath, and compel the attendance of witnesses, the giving of testimony, and the production of records.

191.990. 1. There is hereby created in the state treasury the "Healthcare Technology Fund" which shall consist of all gifts, donations, transfers, moneys appropriated by the general

assembly, and bequests to the fund. The state treasurer shall be custodian of the fund and shall approve disbursements from the fund in accordance with sections 30.170 and 30.180, RSMo. The fund shall be administered by the department of social services. The fund shall be created no later than July 1, 2006, provided however, that if the effective date of this act is after July 1, 2006, then the fund shall be created no later than such effective date.

2. Upon appropriation, moneys in the fund shall be used to promote technological advances to improve patient care, decrease administrative burdens, and increase patient and healthcare provider satisfaction. Such programs or improvements on technology shall include encouragement and implementation of technologies intended to improve the safety, quality, and costs of healthcare services in the state including, but not limited to, the following:

(1) Electronic medical records;

(2) Community health records;

(3) Personal health records;

(4) E-prescribing;

(5) Telemedicine; and

(6) Telemonitoring.

3. It is hereby declared to be the policy of the state of Missouri that funds from the Healthcare Technology Fund shall not be expended for political purposes and shall not be expended to the financial benefit of any elected public official or any state employee who has direct decision-making or administrative authority over disbursements from the fund. No moneys in the

Healthcare Technology Fund shall be appropriated or expended for products or services provided by any business or corporation:

(1) At least one-half of one percent of which is beneficially owned by any elected public official or any state employee who has direct decision-making or administrative authority over disbursements from the fund;

(2) Which has a director who is an elected public official or any state employee who has direct decision-making or administrative authority over disbursements from the fund; or

(3) Which has an executive officer or executive manager who is an elected public official or any state employee who has direct decision-making or administrative authority over disbursements from the fund.

4. For purposes of this section, the following terms shall have the following meanings:

(1) "Elected public official or any state employee", means a person who holds an elected public office in a municipality, a county government, a state government, or the federal government, or any state employee, and the spouse of either such person, and any relative within one degree of consanguinity or affinity of either such person;

(2) "Executive officer or executive manager", means any person who is a chairman, vice chairman, chief executive officer, chief financial officer, other chief officer, president, any level of vice president, or any other officer or manager who has executive level management duties and reports directly to the directors or to any chairman, chief officer or president of the business or corporation.

5. Any amounts appropriated or expended from the Healthcare Technology Fund in violation of this section shall be remitted by the payee to the fund with interest paid at the rate of one percent per month. The attorney general is authorized to take all necessary action to enforce the provisions of this section, including, but not limited to, obtaining an order for injunction from a court of competent jurisdiction to stop payments from being made from the fund in violation of this section.

6. At least twenty-five percent of the funds annually disbursed shall be dedicated to technological upgrades and promotion of technological advances in accordance with subsection 2 of this section in medically under-served communities and populations.

7. Any moneys remaining in the fund at the end of the biennium shall revert to the credit of the general revenue fund, except for moneys that were gifts, donations, or bequests.

8. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

9. The department of social services shall promulgate rules setting forth the procedures and methods of implementing the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general

assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2006, shall be invalid and void.

208.146. 1. This section shall be known as the "Disabled Employee's Health Assistance Program". Subject to appropriations and in accordance with the federal Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), Public Law 106-170, the medical assistance provided for in section 208.151 may be paid for a person who is employed and who:

(1) Except for earnings, meets the definition of disabled under the Supplemental Security Income Program or meets the definition of an employed individual with a medically improved disability under TWWIIA;

(2) Has earned income, as defined in subsection 2 of this section;

(3) Meets the asset limits in subsection 3 of this section;

(4) Has net income, as defined in subsection 3 of this section, that does not exceed the limit for permanent and totally disabled (PTD) individuals to receive nonspenddown Medicaid under subdivision (24) of subsection 1 of section 208.151; and

(5) Has a gross income that does not exceed the gross income limit authorized by annual appropriation. The gross income limit shall not exceed two hundred fifty percent or less of the federal poverty level. For purposes of this subdivision, "gross income" includes all income of the person and the person's spouse that would be considered in determining Medicaid

eligibility for permanent and totally disabled (PTD) individuals under subdivision (24) of subsection 1 of section 208.151. Individuals with gross incomes in excess of one hundred percent of the federal poverty level shall pay a premium for participation in accordance with subsection 4 of this section.

2. For income to be considered earned income for purposes of this section, the department of social services shall document that Medicare and Social Security taxes are withheld from such income. Self-employed persons shall provide proof of payment of Medicare and Social Security taxes for income to be considered earned.

3. (1) For purposes of determining eligibility under this section, the available asset limit and the definition of available assets shall be the same as those used to determine Medicaid eligibility for permanent and totally disabled (PTD) individuals under subdivision (24) of subsection 1 of section 208.151 except for:

(a) Medical savings accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year;

(b) Independent living accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year. For purposes of this section, an "independent living account" means an account established and maintained to provide savings for transportation, housing, home modification, and personal care services and assistive devices

associated with such person's disability.

(2) To determine net income, the following shall be disregarded:

(a) All earned income of the disabled worker;

(b) The first sixty-five dollars and one-half of the remaining earned income of a nondisabled spouse's earned income;

(c) A twenty-dollar standard deduction;

(d) Health insurance premiums;

(e) All Supplemental Security Income (SSI) payments;

(f) A standard deduction for impairment-related employment expenses if authorized by annual appropriation. This deduction shall not exceed an amount equal to one-half of the disabled worker's earned income and not exceed three hundred dollars a month.

4. Any person whose gross income exceeds one hundred percent of the federal poverty level shall pay a premium for participation in the medical assistance provided in this section. Such premium shall be:

(1) For a person whose gross income is more than one hundred percent but less than one hundred fifty percent of the federal poverty level, seven and one-half percent of income at one hundred percent of the federal poverty level;

(2) For a person whose gross income equals or exceeds one hundred fifty percent but is less than two hundred percent of the federal poverty level, seven and one-half percent of income at one hundred fifty percent of the federal poverty level;

(3) For a person whose gross income equals or exceeds two hundred percent of the federal poverty level, seven and one-half

percent of income at two hundred percent of the federal poverty level.

5. Recipients of services through this program shall report any change in income or household size within ten days of the occurrence of such change. An increase in premiums resulting from a reported change in income or household size shall be effective with the next premium invoice that is mailed to a person after due process requirements have been met. A decrease in premiums shall be effective the first day of the month immediately following the month in which the change is reported.

6. If an eligible person's employer offers employer-sponsored health insurance and the department of social services determines that it is more cost effective, such person shall participate in the employer-sponsored insurance. The department shall pay such person's portion of the premiums, co-payments, and any other costs associated with participation in the employer-sponsored health insurance.

7. The department of social services shall apply for any and all grants that may be available to offset the costs associated with the implementation of this section.

8. Recipients of services through this program who pay a premium shall do so by electronic funds transfer or employer deduction unless good cause is shown to pay otherwise.

9. The provisions of this section shall expire on June 30, 2008.

208.151. 1. For the purpose of paying medical assistance on behalf of needy persons and to comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42

U.S.C. Section 301 et seq.) as amended, the following needy persons shall be eligible to receive medical assistance to the extent and in the manner hereinafter provided:

(1) All recipients of state supplemental payments for the aged, blind and disabled;

(2) All recipients of aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040;

(3) All recipients of blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31, 1973, or less restrictive standards as established by rule of the family support division, who are sixty-five years of age or over and are patients in state institutions for mental diseases or tuberculosis;

(5) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children except for the requirements of subdivision (2) of subsection 1 of section 208.040, and who are residing in an intermediate care facility, or receiving active treatment as inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. 1396d, as amended;

(6) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children benefits except for the requirement of deprivation of parental support as

provided for in subdivision (2) of subsection 1 of section 208.040;

(7) All persons eligible to receive nursing care benefits;

(8) All recipients of family foster home or nonprofit private child-care institution care, subsidized adoption benefits and parental school care wherein state funds are used as partial or full payment for such care;

(9) All persons who were recipients of old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet the eligibility requirements, except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

(10) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child in the home;

(11) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child who is deprived of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(12) Pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to one hundred eighty-five percent of the federal poverty level as established and amended by the federal Department of Health and Human Services, or its successor agency;

(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical

assistance under 6401 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The family support division shall use an income eligibility standard equal to one hundred thirty-three percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency;

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the family support division shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide Medicaid coverage under this subdivision, the department of social services may revise the state Medicaid plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

(15) The family support division shall not establish a resource eligibility standard in assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The division of medical services shall define the amount and scope of benefits which are available to individuals eligible under each of the subdivisions (12), (13), and (14) of this

subsection, in accordance with the requirements of federal law and regulations promulgated thereunder;

(16) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal care shall be made available to pregnant women during a period of presumptive eligibility pursuant to 42 U.S.C. Section 1396r-1, as amended;

(17) A child born to a woman eligible for and receiving medical assistance under this section on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of time determined in accordance with applicable federal and state law and regulations so long as the child is a member of the woman's household and either the woman remains eligible for such assistance or for children born on or after January 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon notification of such child's birth, the family support division shall assign a medical assistance eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

(18) Pregnant women and children eligible for medical assistance pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for medical assistance benefits be required to apply for aid to families with dependent children. The family support division shall utilize an application for eligibility for such persons which eliminates information requirements other than those necessary to apply for

medical assistance. The division shall provide such application forms to applicants whose preliminary income information indicates that they are ineligible for aid to families with dependent children. Applicants for medical assistance benefits under subdivision (12), (13) or (14) shall be informed of the aid to families with dependent children program and that they are entitled to apply for such benefits. Any forms utilized by the family support division for assessing eligibility under this chapter shall be as simple as practicable;

(19) Subject to appropriations necessary to recruit and train such staff, the family support division shall provide one or more full-time, permanent case workers to process applications for medical assistance at the site of a health care provider, if the health care provider requests the placement of such case workers and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment, of such case workers. The division may provide a health care provider with a part-time or temporary case worker at the site of a health care provider if the health care provider requests the placement of such a case worker and reimburses the division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such a case worker. The division may seek to employ such case workers who are otherwise qualified for such positions and who are current or former welfare recipients. The division may consider training such current or former welfare recipients as case workers for this program;

(20) Pregnant women who are eligible for, have applied for and have received medical assistance under subdivision (2), (10), (11) or (12) of this subsection shall continue to be considered eligible for all pregnancy-related and postpartum medical assistance provided under section 208.152 until the end of the sixty-day period beginning on the last day of their pregnancy;

(21) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192, RSMo, or chapter 205, RSMo, or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of mental retardation program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective Medicaid-eligible high-risk mothers and enroll them in the

state's Medicaid program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the Medicaid program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any Medicaid prepaid, case-managed programs;

(22) By January 1, 1988, the department of social services and the department of health and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207, RSMo;

(23) All recipients who would be eligible for aid to families with dependent children benefits except for the requirements of paragraph (d) of subdivision (1) of section 208.150;

(24) (a) All persons who would be determined to be eligible for old age assistance benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the Medicaid state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriation;

(b) All persons who would be determined to be eligible for

aid to the blind benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the Medicaid state plan as of January 1, 2005, except that less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level;

(c) All persons who would be determined to be eligible for permanent and total disability benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. 1396a(f); or less restrictive methodologies as contained in the Medicaid state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriations. Eligibility standards for permanent and total disability benefits shall not be limited by age. Any income earned through certified extended employment at a sheltered workshop under chapter 178, RSMo, shall not be considered as income for purposes of determining eligibility under this subdivision;

(25) Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1.

2. Rules and regulations to implement this section shall be promulgated in accordance with section 431.064, RSMo, and chapter 536, RSMo. Any rule or portion of a rule, as that term is

defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for medical assistance for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for medical assistance for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each

family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive medical assistance without fee for an additional six months. The division of medical services may provide by rule and as authorized by annual appropriation the scope of medical assistance coverage to be granted to such families.

4. When any individual has been determined to be eligible for medical assistance, such medical assistance will be made available to him or her for care and services furnished in or after the third month before the month in which he made application for such assistance if such individual was, or upon application would have been, eligible for such assistance at the time such care and services were furnished; provided, further, that such medical expenses remain unpaid.

5. The department of social services may apply to the federal Department of Health and Human Services for a Medicaid waiver amendment to the Section 1115 demonstration waiver or for any additional Medicaid waivers necessary not to exceed one million dollars in additional costs to the state. A request for such a waiver so submitted shall only become effective by executive order not sooner than ninety days after the final adjournment of the session of the general assembly to which it is submitted, unless it is disapproved within sixty days of its submission to a regular session by a senate or house resolution adopted by a majority vote of the respective elected members

thereof.

6. Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for medical assistance benefits under subdivisions (1) to (22) of subsection 1 of this section shall only be eligible if annual appropriations are made for such eligibility. This subsection shall not apply to classes of individuals listed in 42 U.S.C. Section 1396a(a)(10)(A)(i).

208.640. 1. Parents and guardians of uninsured children with incomes between one hundred fifty-one and three hundred percent of the federal poverty level who do not have access to affordable employer-sponsored health care insurance or other affordable health care coverage may obtain coverage pursuant to this section.

2. For the purposes of sections 208.631 to 208.657, "affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance **[**requiring**]** plans that cover all pre-existing conditions that require a monthly premium less than or equal to **[**one hundred thirty-three percent of the monthly average premium required in the state's current Missouri consolidated health care plan**]**:

(1) Seventy percent of the monthly average premium required in the state's current Missouri consolidated health care plan for parents and guardians with incomes between one hundred fifty-one percent and one hundred eighty-five percent of the federal poverty level;

(2) Eighty-five percent of the monthly average premium required in the state's current Missouri consolidated health care

plan for parents and guardians with incomes between one hundred eighty-six percent and two hundred twenty-five percent of the federal poverty level;

(3) One hundred percent of the monthly average premium required in the state's current Missouri consolidated health care plan for parents and guardians with incomes between two hundred twenty-six percent and three hundred percent of the federal poverty level.

3. The parents and guardians of eligible uninsured children pursuant to this section are responsible for a monthly premium equal to the average premium required for the Missouri consolidated health care plan; provided that the total aggregate cost sharing for a family covered by these sections shall not exceed five percent of such family's income for the years involved. No co-payments or other cost sharing is permitted with respect to benefits for well-baby and well-child care including age-appropriate immunizations. Cost-sharing provisions pursuant to sections 208.631 to 208.657 shall not exceed the limits established by 42 U.S.C. Section 1397cc(e).

Section B. Because immediate action is necessary to provide medical assistance to the employed disabled and to uninsured children in this state, the enactment of section 208.146 and the repeal and reenactment of sections 208.151 and 208.640 of this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the enactment of section 208.146 and the repeal and reenactment of sections 208.151 and 208.640 of this act shall be

in full force and effect on July 1, 2006, upon its passage and approval, whichever later occurs.

Section C. Because of the pending fiscal and health care crisis in Missouri, the enactment of sections 191.006 and 191.990, of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the enactment of sections 191.006 and 191.990, of this act shall be in full force and effect upon its passage and approval.