SECOND REGULAR SESSION

HOUSE BILL NO. 1558

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE HUGHES.

Pre-filed January 8, 2008 and copies ordered printed.

D. ADAM CRUMBLISS, Chief Clerk

3994L.01I

AN ACT

Relating to the Missouri Universal Health Insurance Act, with a referendum clause.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section 1. 1. Sections 1 to 18 of this act shall be known and may be cited as the "Missouri Universal Health Insurance Act".

2. As used in sections 1 to 18 of this act, the following terms shall mean:

(1) "Director", the director of the department of health and senior services;

(2) "Program", the program of benefits under sections 1 to 18 of this act;

(3) "Regional offices", the regional offices established under section 15 of this act;

(4) "Regional directors", the directors of the regional offices established under section 15 of this act;

(5) "State board of universal quality and access" or "board", the board established under section 17 of this act.

Section 2. 1. There is hereby established the "Universal Health Insurance Program" within the department of health and senior services. All residents of this state shall be eligible for coverage under the program. Coverage under the program shall entitle residents and their families to a universal, best quality standard of care.

2. Any resident wishing to participate in the program shall fill out a state health insurance card application form. The department shall develop such form, which shall be no more than two pages in length, and shall make the form available to the public through health care providers in this state.

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

3. Residents who apply for coverage under the program from a participating provider shall be presumed to be eligible for health benefits under sections 1 to 18 of this act, but shall complete an application for benefits in order to receive a state health insurance card and have payment made for such benefits.

Section 3. 1. The health insurance benefits under sections 1 to 18 of this act shall cover all medically necessary services, including:

(1) Primary care and prevention;

(2) Inpatient care;

(3) Outpatient care;

(4) Emergency care;

(5) Prescription drugs;

(6) Durable medical equipment;

(7) Long-term care;

(8) Mental health services;

(9) The full scope of dental services other than cosmetic dentistry;

(10) Substance abuse treatment services;

(11) Chiropractic services; and

(12) Basic vision care and vision correction other than laser vision correction for cosmetic purposes.

2. Benefits under subsection 1 of this section shall be available through any licensed health care provider in this state that is legally qualified to provide such benefits.

3. No deductibles, copayments, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits.

Section 4. 1. (1) No institution shall be a participating provider unless such institution is a public or nonprofit institution.

(2) Investor-owned providers of care opting to participate in the program convert to nonprofit status. The owners of such providers shall be compensated for the actual appraised value of converted facilities used in the delivery of care. The general assembly shall appropriate moneys necessary to compensate investor-owned providers for the conversion of facilities. The conversion to a nonprofit health care system shall take place over a fifteen-year period through the sale of bonds. Payment for conversions under this subdivision shall not be made for loss of business profits, but shall be made only for costs associated with the conversion of real property and equipment.

2. Health care delivery facilities participating in the program shall meet state quality and licensing guidelines as a condition of participation under the program, including guidelines regarding safe staffing and quality of care. Participating health care

professionals shall be licensed in this state and meet the quality standards for such professional's area of care. No health care professional whose license is suspended or who is under disciplinary action in this state shall be a participating provider.

3. Nonprofit health maintenance organizations that actually deliver care in their own facilities and employ health care professionals on a salaried basis may participate in the program and receive global budgets or capitation payments as specified in section 7 of this act. Other health maintenance organizations, including those which principally contract to pay for services delivered by nonemployees, shall be classified as insurance plans. Such organizations shall not be participating providers and shall be subject to the restriction against duplication of coverage in section 5 of this act.

Section 5. No private health insurer shall sell health insurance coverage that duplicates the benefits provided under sections 1 to 18 of this act. Nothing in sections 1 to 18 of this act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered under sections 1 to 18 of this act, such as cosmetic surgery or other services or items not medically necessary.

Section 6. 1. To carry out the provisions of sections 1 to 18 of this act, there is hereby established on an annual basis consistent with sections 6 to 12 of this act:

(1) An operating budget;

(2) A capital expenditures budget;

(3) Reimbursement levels for providers consistent with sections 11 and 12 of this act; and

(4) A health care professional education budget, including amounts for the continued funding of resident physician training programs.

Upon appropriations, the director shall provide the regional offices with an annual funding allotment to cover the costs of each region's expenditures. Such allotment shall cover global budgets, reimbursements to health care professionals, and capital expenditures.

2. The operating budget shall be used for:

(1) Payment for services rendered by health care professionals;

(2) Global budgets for institutional providers;

(3) Capitation payments for capitated groups; and

(4) Administration of the program.

3. The capital expenditures budget shall be used for moneys needed for:

(1) The construction or renovation of health facilities; and

(2) For major equipment purchases.

4. Moneys earmarked for operations for capital expenditures shall not be commingled with moneys earmarked for capital expenditures for operations.

Section 7. 1. (1) The program, through regional offices, shall pay each hospital, long-term care facility, health care facility, home health agency, or other institutional provider or prepaid group practice a monthly lump sum to cover all operating expenses under a global budget.

(2) The global budget of a provider shall be established through negotiations between providers and regional directors, subject to approval of the director of the department of health and senior services. The budget shall be negotiated annually, based on past expenditures, projected changes in levels of services, wages and input, costs, and proposed new and innovative programs.

2. (1) The program shall pay physicians, dentists, psychologists, chiropractors, optometrists, nurse practitioners, nurse midwives, physicians' assistants, and other advanced practice professionals licensed and regulated by the state as follows:

(a) Fee-for-service payment under subdivision (2) of this subsection;

(b) Salaried positions in institutions receiving global budgets under subdivision (3) of this subsection;

(c) Salaried positions within group practices or nonprofit health maintenance organizations receiving capitation payments under subdivision (4) of this subsection.

(2) (a) The program shall negotiate a simplified fee schedule that is fair with representatives of physicians and other health care professionals, after close consultation with the state board of universal quality and access and the regional directors. Initially, the current prevailing fees or reimbursement shall be the basis for the fee negotiation for all professional services covered under sections 1 to 18 of this act.

(b) In establishing such schedule, the director shall take into consideration regional differences in reimbursement, but strive for a uniform statewide standard.

(c) The director, in consultation with representatives of the physician community in this state, shall establish and appoint a physician practice review board to assure quality, cost-effectiveness, and fair reimbursements for physician-delivered services.

(d) The director shall promulgate guidelines for all providers.

(e) Under sections 1 to 18 of this act, physicians shall submit bills to the regional director on a simple form. Such forms shall be available in electronic format for submission by computer. Interest shall be paid to providers whose bills are not paid within thirty days of submission.

(f) Licensed health care professionals who accept any payment from the program shall not bill any patient for any covered service.

(g) The director shall make a good faith effort to create a uniform computerized electronic billing system, including those areas of the state where electronic billing is not yet established.

(3) (a) In the case of an institution, such as a hospital, health care center, group practice, community health center, or home health agency that elects to be paid a monthly global budget for the delivery of health care as well as for education and prevention programs, physicians employed by such institutions shall be reimbursed through a salary included as part of such budget.

(b) Salary ranges for health care providers shall be determined in the same way as fee schedules under subdivision (2) of this subsection.

(4) (a) Health maintenance organizations, group practices, and other institutions may elect to be paid capitation premiums to cover all outpatient, physician, and medical home health care provided to persons enrolled to receive benefits through the organization or entity.

(b) Such capitation may include the costs of services of licensed physicians and other licensed independent practitioners provided to inpatients. Other costs of inpatient and institutional care shall be excluded from capitation payments, and shall be covered under the institution's global budget.

(c) Selective enrollment policies are prohibited, and patients shall be permitted to enroll or disenroll from such organizations or entities with appropriate notice.

(d) Under sections 1 to 18 of this act:

a. Health maintenance organizations shall be required to reimburse physicians based on a salary; and

b. Financial incentives between such organizations and physicians based on utilization are prohibited.

Section 8. 1. The program shall provide for each region a single budgetary allotment to cover a full array of long-term care services under sections 1 to 18 of this act.

2. Each region shall provide a global budget to local long-term care providers for the full range of needed services, including in-home, nursing home, and community-based care.

3. Budgets for long-term care services under this section shall be based on past expenditures, financial and clinical performance, utilization, and projected changes in service, wages, and other related factors.

4. All efforts shall be made under sections 1 to 18 of this act to provide long-term care in a home- or community-based setting, as opposed to institutional care.

Section 9. 1. The program shall provide coverage for all medically necessary mental health care on the same basis as the coverage for other conditions. Licensed mental health professionals shall be paid in the same manner as specified for other health care professionals, as provided in subsection 2 of section 7 of this act.

2. The program shall cover supportive residences, occupational therapy, and ongoing mental health and counseling services outside the hospital for patients with serious mental illness. In all cases the highest quality and most effective care shall be delivered, and, for some persons, this may mean institutional care.

Section 10. 1. The prices to be paid each year under sections 1 to 18 of this act for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment shall be negotiated annually by the program.

2. (1) The program shall establish a prescription drug formulary system, which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(2) The formulary shall promote the use of generic medications but allow the use of brand-name and off-formulary medications when indicated for a specific patient or condition.

(3) The formulary shall be updated frequently and health care professionals and patients may petition their region or the director to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

Section 11. 1. The program shall be funded as provided in subsections 2 and 3 of this section.

2. Such moneys as may be necessary to carry out sections 1 to 18 of this act are authorized to be appropriated.

3. Moneys appropriated under subsection 2 of this section shall be paid for:

(1) By vastly reduced paperwork;

(2) By requiring a rational bulk procurement of medications;

(3) From existing sources of state revenues for health care;

(4) By increasing personal income taxes on the top five percent income earners;

(5) By instituting a modest payroll tax; and

(6) By instituting a small tax on stock and bond transactions.

Section 12. The general assembly shall appropriate funds equivalent to the amounts the director estimates would have been appropriated and expended for state public health care programs for the uninsured and indigent, including funds appropriated under the Medicaid program and children's health insurance program.

Section 13. 1. Except as otherwise specifically provided, sections 1 to 18 of this act shall be administered by the director of the department of health and senior services.

2. The director shall appoint a director for a division of long-term care under the program who shall be responsible for administration of sections 1 to 18 of this act and ensuring the availability and accessibility of high quality long-term care services.

3. The director shall appoint a director for a division of mental health under the program who shall be responsible for administration of sections 1 to 18 of this act and ensuring the availability of high quality mental health services.

Section 14. The director shall appoint a director for an office of quality control under the program. Such office director shall, after consultation with regional directors, provide annual recommendations to the director of the department of health and senior services, the governor, and the general assembly on how to ensure the highest quality health care service delivery. The office director shall conduct an annual review on the adequacy of medically necessary services and shall make recommendations of any proposed changes to the director of the department of health and senior services, the governor, and the general assembly.

Section 15. 1. The program shall establish and maintain regional offices. Such regional offices may be combined with or replace any local health department agencies.

2. In each regional office there shall be one regional director appointed by the director of the department of health and senior services.

3. (1) Regional offices of the program shall be responsible for:

(a) Coordinating funding to health care providers and physicians; and

(b) Coordinating billing and reimbursements with physicians and health care providers through a state reimbursement system.

4. The director of the department of health and senior services shall be responsible for the following duties:

(1) Providing an annual state health care needs assessment report to the state board of universal quality and access and the regional directors after a thorough examination of health needs, in consultation with public health officials, health care professionals, patients, and patient advocates;

(2) Health planning, including oversight of the placement of new hospitals, clinics, and other health care delivery facilities;

(3) Health planning, including oversight of the purchase and placement of new health equipment to ensure timely access to care and to avoid duplication;

(4) Submitting global budgets to the regional directors;

(5) Recommending changes in provider reimbursement or payment for delivery of health services in this state;

(6) Establishing a quality assurance mechanism in this state to minimize under and over utilization and to assure that all providers meet high quality standards; and

(7) Reviewing program disbursements on a quarterly basis and recommending needed adjustments in fee schedules needed to achieve budgetary targets and assure adequate access to needed care.

5. The program shall provide that clerical and administrative workers in insurance companies, doctors offices, hospitals, long-term care facilities, and other facilities whose jobs are eliminated due to reduced administration shall have first priority in retraining and job placement in the new system.

Section 16. 1. The director shall create a standardized, confidential electronic patient record system in accordance with laws and rules to maintain accurate records and to simplify the billing process, thereby reducing medical errors and bureaucracy.

2. Notwithstanding that all billing shall be performed electronically, patients shall have the option of keeping any portion of their medical records separate from their electronic medical record.

Section 17. 1. (1) There is hereby established the "State Board of Universal Quality and Access", which shall consist of fifteen members appointed by the governor, with the advice and consent of the senate.

(2) The appointed members of the board shall include at least one of each of the following:

(a) Health care professionals;

(b) Representatives of institutional providers of health care;

(c) Representatives of health care advocacy groups;

(d) Representatives of labor unions; and

(e) Citizen patient advocates.

(3) Each member shall be appointed for a term of six years, except that the governor shall stagger the terms of members initially appointed so that no more than three members' terms expire in any one year.

(4) No member of the board shall have a financial conflict of interest with the duties before the board.

2. (1) The board shall meet at least twice a year and shall advise the director on a regular basis to ensure quality, access, and affordability.

(2) The board shall specifically address the following issues:

(a) Access to care;

(b) Quality improvement;

(c) Efficiency of administration;

(d) Adequacy of budget and funding;

(e) Appropriateness of reimbursement levels of health care professionals;

(f) Capital expenditure needs;

(g) Long-term care;

(h) Mental health and substance abuse services; and

(i) Staffing levels and working conditions in health care delivery facilities.

(3) The board shall specifically establish a universal, best quality of standard of care with respect to:

(a) Appropriate staffing levels;

(b) Appropriate medical technology;

(c) Design and scope of work in the health workplace; and

(d) Best practices.

(4) The board shall report its recommendations twice a year to the director, the governor, and the general assembly.

3. The board members may, subject to appropriations, be compensated for their service on the board and shall be reimbursed for any actual and necessary expenses incurred in the performance of their duties.

Section 18. 1. It is the intent of sections 1 to 18 of this act:

(1) That the program at all times stress the importance of good public health through the prevention of disease; and

(2) To reduce health disparities by race, ethnicity, income, and geographic region; and

(3) To provide high quality, cost-effective, culturally appropriate care to all residents of this state regardless of race, ethnicity, sexual orientation, or language.

2. The director shall promulgate rules to implement the provisions of sections 1 to 18 of this act. 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 sections 1 to 18 of this act 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. Sections 1 to 18 of this act 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 the effective date of sections 1 to 18 of this act, shall be invalid and void.

Section B. Section A of this act is hereby submitted to the qualified voters of this state for approval or rejection at an election which is hereby ordered and which shall be held and conducted on the Tuesday immediately following the first Monday in November, 2008, or at a special election to be called by the governor for that purpose, pursuant to the laws and constitutional provisions of this state applicable to general elections and the submission of referendum measures by initiative petition, and it shall become effective when approved by a majority of the votes cast thereon at such election and not otherwise.

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