SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 1283

94TH GENERAL ASSEMBLY

Reported from the Special Committee on Healthcare Transformation May 13, 2008 with recommendation that House Committee Substitute for Senate Substitute for Senate Committee Substitute for Senate Bill No. 1283 Do Pass. Referred to the Committee on Rules pursuant to Rule 25(21)(f).

D. ADAM CRUMBLISS, Chief Clerk

5271L.10C

AN ACT

To repeal sections 33.103, 105.711, 135.535, 135.562, 143.111, 143.113, 143.782, 143.790, 148.380, 191.400, 192.014, 192.083, 197.305, 197.310, 197.315, 197.330, 313.321, 354.536, 374.184, 376.426, 376.450, 376.453, 376.776, 376.960, 376.962, 376.966, 376.973, 376.975, 376.980, 376.984, 376.986, 376.987, 376.990, 379.930, 379.940, 379.952, and 660.062, RSMo, and to enact in lieu thereof seventy-eight new sections relating to the Missouri health transformation act of 2008, with penalty provisions, an emergency clause, and an effective date for certain sections.

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

Section A. Sections 33.103, 105.711, 135.535, 135.562, 143.111, 143.113, 143.782, 143.790, 148.380, 191.400, 192.014, 192.083, 197.305, 197.310, 197.315, 197.330, 313.321, 354.536, 374.184, 376.426, 376.450, 376.453, 376.776, 376.960, 376.962, 376.966, 376.973, 376.975, 376.980, 376.984, 376.986, 376.987, 376.990, 379.930, 379.940, 379.952, and 660.062, RSMo, are repealed and seventy-eight new sections enacted in lieu thereof, to be known as sections 26.850, 26.853, 26.856, 26.859, 33.103, 105.711, 135.535, 135.562, 143.111, 143.782, 143.790, 148.380, 191.845, 191.1005, 191.1008, 191.1010, 191.1200, 191.1250, 191.1256, 191.1259, 191.1265, 191.1271, 192.083, 192.990, 196.1200, 197.305, 197.310, 197.315,

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.

197.330, 197.551, 197.554, 197.557, 197.563, 197.566, 197.572, 197.575, 197.578, 197.581, 197.584, 197.587, 197.588, 197.590, 197.625, 287.055, 313.321, 354.536, 374.184, 376.426, 376.450, 376.453, 376.685, 376.776, 376.960, 376.962, 376.966, 376.981, 376.983, 376.985, 376.986, 376.987, 376.991, 376.1600, 376.1618, 379.930, 379.940, 379.952, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12, to read as follows:

26.850. Sections 26.850 to 26.859 may be cited as the "Health Cabinet and Health Policy Council Act".

26.853. 1. There is hereby created the "Missouri Health Cabinet".

2. The cabinet shall ensure that the public policy of this state relating to health is developed to promote interdepartmental collaboration and program implementation in order that services designed for health are planned, managed, and delivered in a holistic and integrated manner to improve the health of Missourians.

3. The cabinet is created in the executive office of the governor, which shall provide administrative support and service to the cabinet.

4. The cabinet shall meet for its organizational session no later than October 1, 2008. Thereafter, the cabinet shall meet at least six times each year, with two of the meetings in different regions of the state in order to solicit input from the public and any other individual offering testimony relevant to the issues considered. Each meeting shall include a public-comment session.

5. The cabinet shall consist of thirteen members, including the governor and the following persons:

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

(2) Director of the department of social services;

(3) Director of the department of mental health;

(4) Commissioner of education;

(5) Director of the department of insurance, financial institutions and professional registration.

6. The lieutenant governor, president pro tem of the senate, the speaker of the house of representatives, the chief justice of the supreme court, the attorney general, the commissioner of the office of administration, and the director of agriculture, or their appointed designees, shall serve as ex officio members of the cabinet.

7. The governor or the director of the department of health and senior services shall serve as the chairperson of the cabinet.

26.856. The cabinet shall have the following duties and responsibilities:

(1) Develop, no later than July 31, 2009, a plan to integrate services to improve health outcomes. The plan shall align public resources to support the healthy growth and development of Missourians;

(2) Develop and implement measurable outcomes that are consistent with the plan. The cabinet shall establish a baseline measurement for each outcome and regularly report on the progress made toward achieving the desired outcome;

(3) Design and implement actions that will promote collaboration, creativity, increased efficiency, information sharing, and improved service delivery between and within state governmental organizations that provide services related to health;

(4) Foster public awareness of health issues and develop new partners in the effort to improve health;

(5) Create a health impact statement for evaluating proposed legislation, requested appropriations, and programs. The impact statement shall be shared with the general assembly in their deliberative process;

(6) Identify existing and potential funding streams and resources for health programs and services, including, but not limited to, public funding, foundation and organization grants, and other forms of private funding opportunities, including public-private partnerships;

(7) Develop a health-based budget structure and nomenclature that includes all relevant departments, funding streams, and programs. The budget shall facilitate improved coordination and efficiency, explore options for and allow maximization of federal financial participation, and implement the state's vision and strategic plan;

(8) Engage in other activities that will implement improved collaboration of agencies in order to create, manage, and promote coordinated policies, programs, and service-delivery systems that support improved health outcomes;

(9) Provide an annual report by February first of each year to the governor, the president pro tem of the senate, the speaker of the house of representatives, and the public concerning its activities and progress towards making this state the first to reach the Healthy People 2020 goals or any updated Healthy People goals. The annual report may include recommendations for needed legislation or rulemaking authority.

26.859. The governor shall appoint a "Health Policy Council", with the advice and consent of the senate, to assist the cabinet in its tasks. This council replaces the state board of health established in section 191.400, RSMo, and the state board of senior services established in section 660.062, RSMo. The council shall include twenty members who can provide to the cabinet the best available technical and professional research and assistance. The council shall advise the departments of health and senior services and social services

in the development of rules and regulations. It shall include representatives of health policy organizations, health data collection, and analysis experts, health information technology professionals, health educators, licensed health professionals including a minimum of four physicians, including one with experience in geriatrics and one with experience with mental health, one dentist, and one registered nurse, representatives of institutions of higher learning who train the health workforce in the state, health facility operators, insurance providers, employers, health economist, health advocacy organizations, a health professional with focus on senior issues, consumers, wherever practicable, who have been recipients of services and programs operated or funded by state agencies.

33.103. 1. Whenever the employees of any state department, division or agency establish any voluntary retirement plan, or participate in any group hospital service plan, group life insurance plan, medical service plan or other such plan, or if they are members of an employee collective bargaining organization, or if they participate in a group plan for uniform rental, the commissioner of administration may deduct from such employees' compensation warrants the amount necessary for each employee's participation in the plan or collective bargaining dues, provided that such dues deductions shall be made only from those individuals agreeing to such deductions. Before such deductions are made, the person in charge of the department, division or agency shall file with the commissioner of administration an authorization showing the names of participating employees, the amount to be deducted from each such employee's compensation, and the agent authorized to receive the deducted amounts. The amount deducted shall be paid to the authorized agent in the amount of the total deductions by a warrant issued as provided by law.

2. The commissioner of administration may, in the same manner, deduct from any state employee's compensation warrant:

(1) Any amount authorized by the employee for the purchase of shares in a state employees' credit union in Missouri;

(2) Any amount authorized by the employee for contribution to a fund resulting from a united, joint community-wide solicitation or to a fund resulting from a nationwide solicitation by charities rendering services or otherwise fulfilling charitable purposes if the fund is administered in a manner requiring public accountability and public participation in policy decisions;

(3) Any amount authorized by the employee for the payment of dues in an employee association;

(4) Any amount determined to be owed by the employee to the state in accordance with guidelines established by the commissioner of administration which shall include notice to the employee and an appeal process;

(5) Any amount voluntarily assigned by the employee for payment of child support obligations determined pursuant to chapter 452 or 454, RSMo; **[**and**]**

(6) Any amount authorized by the employee for contributions to any "qualified state tuition program" pursuant to Section 529 of the Internal Revenue Code of 1986, as amended, sponsored by the state of Missouri**; and**

(7) Any amount for cafeteria plan administrative fees under subdivision (4) of subsection 3 of this section.

3. The commissioner of administration may establish a cafeteria plan in accordance with Section 125 of Title 26 United States Code for state employees. The commissioner of administration must file a written plan document to be filed in accordance with chapter 536, RSMo. Employees must be furnished with a summary plan description one hundred twenty days prior to the effective date of the plan. In connection with such plans, the commissioner may:

(1) Include as an option in the plan any employee benefit, otherwise available to state employees, administered by a statutorily created retirement system;

(2) Provide and administer, or select companies on the basis of competitive bids or proposals to provide or administer, any group insurance, or other plan which may be included as part of a cafeteria plan, provided such plan is not duplicative of any other plan, otherwise available to state employees, administered by a statutorily created retirement system;

(3) Include as an option in the plan any other product eligible under Section 125 of Title 26 of the United States Code **the selection of which may be solicited by a vendor on site in state facilities**, subject to regulations promulgated by the office of administration, and including payment to the state by vendors providing those products for the cost of administering those deductions, as set by the office of administration; and

(4) Reduce each **[**participating**]** employee's compensation warrant by the amount necessary for each employee's participation in the cafeteria plan, **[**provided that such salary reduction shall be made only with respect to those individuals agreeing to such reduction**] except for those individual employees who affirmatively elect not to participate in the cafeteria plan**. No such reduction in salary for the purpose of participation in a cafeteria plan shall have the effect of reducing the compensation amount used in calculating the state employee's retirement benefit under a statutorily created retirement system or reducing the compensation amount used in calculating the state employee's compensation or wages for purposes of any workers' compensation claim governed by chapter 287, RSMo.

4. Employees may authorize deductions as provided in this section in writing or by electronic enrollment.

105.711. 1. There is hereby created a "State Legal Expense Fund" which shall consist of moneys appropriated to the fund by the general assembly and moneys otherwise credited to such fund pursuant to section 105.716.

2. Moneys in the state legal expense fund shall be available for the payment of any claim or any amount required by any final judgment rendered by a court of competent jurisdiction against:

(1) The state of Missouri, or any agency of the state, pursuant to section 536.050 or 536.087, RSMo, or section 537.600, RSMo;

(2) Any officer or employee of the state of Missouri or any agency of the state, including, without limitation, elected officials, appointees, members of state boards or commissions, and members of the Missouri national guard upon conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state, or any agency of the state, provided that moneys in this fund shall not be available for payment of claims made under chapter 287, RSMo;

(3) (a) Any physician, psychiatrist, pharmacist, podiatrist, dentist, nurse, or other health care provider licensed to practice in Missouri under the provisions of chapter 330, 332, 334, 335, 336, 337 or 338, RSMo, who is employed by the state of Missouri or any agency of the state, under formal contract to conduct disability reviews on behalf of the department of elementary and secondary education or provide services to patients or inmates of state correctional facilities on a part-time basis, and any physician, psychiatrist, pharmacist, podiatrist, dentist, nurse, or other health care provider licensed to practice in Missouri under the provisions of chapter 330, 332, 334, 335, 336, 337, or 338, RSMo, who is under formal contract to provide services to patients or inmates at a county jail on a part-time basis;

(b) Any physician licensed to practice medicine in Missouri under the provisions of chapter 334, RSMo, and his professional corporation organized pursuant to chapter 356, RSMo, who is employed by or under contract with a city or county health department organized under chapter 192, RSMo, or chapter 205, RSMo, or a city health department operating under a city charter, or a combined city-county health department to provide services to patients for medical care caused by pregnancy, delivery, and child care, if such medical services are provided by the physician pursuant to the contract without compensation or the physician is paid from no other source than a governmental agency except for patient co-payments required by federal or state law or local ordinance;

(c) Any physician licensed to practice medicine in Missouri under the provisions of chapter 334, RSMo, who is employed by or under contract with a federally funded community

health center organized under Section 315, 329, 330 or 340 of the Public Health Services Act (42 U.S.C. 216, 254c) to provide services to patients for medical care caused by pregnancy, delivery, and child care, if such medical services are provided by the physician pursuant to the contract or employment agreement without compensation or the physician is paid from no other source than a governmental agency or such a federally funded community health center except for patient co-payments required by federal or state law or local ordinance. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of one million dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause against any such physician, and shall not exceed one million dollars for any one claimant;

(d) Any physician licensed pursuant to chapter 334, RSMo, who is affiliated with and receives no compensation from a nonprofit entity qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, which offers a free health screening in any setting or any physician, nurse, physician assistant, dental hygienist, dentist, or other health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, who provides health care services within the scope of his or her license or registration at a city or county health department organized under chapter 192, RSMo, or chapter 205, RSMo, a city health department operating under a city charter, or a combined city-county health department, or a nonprofit community health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, if such services are restricted to primary care and preventive health services, provided that such services shall not include the performance of an abortion, and if such health services are provided by the health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, without compensation. MO HealthNet or Medicare payments for primary care and preventive health services provided by a health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, who volunteers at a free health clinic is not compensation for the purpose of this section if the total payment is assigned to the free health clinic. For the purposes of the section, "free health clinic" means a nonprofit community health center qualified as exempt from federal taxation under Section 501 (c)(3) of the Internal Revenue Code of 1987, as amended, that provides primary care and preventive health services to people without health insurance coverage for the services provided without charge. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars, for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand

dollars. Liability or malpractice insurance obtained and maintained in force by or on behalf of any health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, shall not be considered available to pay that portion of a judgment or claim for which the state legal expense fund is liable under this paragraph;

(e) Any physician, nurse, physician assistant, dental hygienist, or dentist licensed or registered to practice medicine, nursing, or dentistry or to act as a physician assistant or dental hygienist in Missouri under the provisions of chapter 332, RSMo, chapter 334, RSMo, or chapter 335, RSMo, who provides medical, nursing, or dental treatment within the scope of his license or registration to students of a school whether a public, private, or parochial elementary or secondary school, if such physician's treatment is restricted to primary care and preventive health services and if such medical, dental, or nursing services are provided by the physician, dentist, physician assistant, dental hygienist, or nurse without compensation. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars, for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars; or

(f) Any physician licensed under chapter 334, RSMo, **and such physician's professional corporation organized under chapter 356, RSMo,** or dentist licensed under chapter 332, RSMo, providing medical care without compensation to an individual referred to his or her care by a city or county health department organized under chapter 192 or 205, RSMo, a city health department operating under a city charter, or a combined city-county health department, or nonprofit health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or a federally funded community health center organized under Section 315, 329, 330, or 340 of the Public Health Services Act, 42 U.S.C. Section 216, 254c**, or a charitable health care referral network qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended**; provided that such treatment shall not include the performance of an abortion. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of one million dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed one million dollars for any one claimant, and insurance policies purchased under the provisions of section 105.721 shall be limited to one million dollars. Liability or malpractice insurance obtained and maintained in force by or on behalf of any physician licensed under chapter 334, RSMo, or any dentist licensed under chapter 332, RSMo,

shall not be considered available to pay that portion of a judgment or claim for which the state legal expense fund is liable under this paragraph;

(4) Staff employed by the juvenile division of any judicial circuit;

(5) Any attorney licensed to practice law in the state of Missouri who practices law at or through a nonprofit community social services center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or through any agency of any federal, state, or local government, if such legal practice is provided by the attorney without compensation. In the case of any claim or judgment that arises under this subdivision, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars; or

(6) Any social welfare board created under section 205.770, RSMo, and the members and officers thereof upon conduct of such officer or employee while acting in his or her capacity as a board member or officer, and any physician, nurse, physician assistant, dental hygienist, dentist, or other health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, who is referred to provide medical care without compensation by the board and who provides health care services within the scope of his or her license or registration as prescribed by the board.

3. The department of health and senior services shall promulgate rules regarding contract procedures and the documentation of care provided under paragraphs (b), (c), (d), (e), and (f) of subdivision (3) of subsection 2 of this section. The limitation on payments from the state legal expense fund or any policy of insurance procured pursuant to the provisions of section 105.721, provided in subsection 7 of this section, shall not apply to any claim or judgment arising under paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section. Any claim or judgment arising under paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section shall be paid by the state legal expense fund or any policy of insurance procured pursuant to section 105.721, to the extent damages are allowed under sections 538.205 to 538.235, RSMo. Liability or malpractice insurance obtained and maintained in force by any health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, for coverage concerning his or her private practice and assets shall not be considered available under subsection 7 of this section to pay that portion of a judgment or claim for which the state legal expense fund is liable under paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section. However, a health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, may purchase liability

or malpractice insurance for coverage of liability claims or judgments based upon care rendered under paragraphs (c), (d), (e), and (f) of subdivision (3) of subsection 2 of this section which exceed the amount of liability coverage provided by the state legal expense fund under those paragraphs. Even if paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section is repealed or modified, the state legal expense fund shall be available for damages which occur while the pertinent paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section is in effect.

4. The attorney general shall promulgate rules regarding contract procedures and the documentation of legal practice provided under subdivision (5) of subsection 2 of this section. The limitation on payments from the state legal expense fund or any policy of insurance procured pursuant to section 105.721 as provided in subsection 7 of this section shall not apply to any claim or judgment arising under subdivision (5) of subsection 2 of this section. Any claim or judgment arising under subdivision (5) of subsection 2 of this section shall be paid by the state legal expense fund or any policy of insurance procured pursuant to section 105.721 to the extent damages are allowed under sections 538.205 to 538.235, RSMo. Liability or malpractice insurance otherwise obtained and maintained in force shall not be considered available under subsection 7 of this section to pay that portion of a judgment or claim for which the state legal expense fund is liable under subdivision (5) of subsection 2 of this section. However, an attorney may obtain liability or malpractice insurance for coverage of liability claims or judgments based upon legal practice rendered under subdivision (5) of subsection 2 of this section that exceed the amount of liability coverage provided by the state legal expense fund under subdivision (5) of subsection 2 of this section. Even if subdivision (5) of subsection 2 of this section is repealed or amended, the state legal expense fund shall be available for damages that occur while the pertinent subdivision (5) of subsection 2 of this section is in effect.

5. All payments shall be made from the state legal expense fund by the commissioner of administration with the approval of the attorney general. Payment from the state legal expense fund of a claim or final judgment award against a health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, described in paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section, or against an attorney in subdivision (5) of subsection 2 of this section, shall only be made for services rendered in accordance with the conditions of such paragraphs. In the case of any claim or judgment against an officer or employee of the state or any agency of the state based upon conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state or any agency of the state that would give rise to a cause of action under section 537.600, RSMo, the state legal expense fund shall be liable, excluding punitive damages, for:

(1) Economic damages to any one claimant; and

(2) Up to three hundred fifty thousand dollars for noneconomic damages.

The state legal expense fund shall be the exclusive remedy and shall preclude any other civil actions or proceedings for money damages arising out of or relating to the same subject matter against the state officer or employee, or the officer's or employee's estate. No officer or employee of the state or any agency of the state shall be individually liable in his or her personal capacity for conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state or any agency of the state. The provisions of this subsection shall not apply to any defendant who is not an officer or employee of the state or any agency of the state in any proceeding against an officer or employee of the state or any agency of the state. Nothing in this subsection shall limit the rights and remedies otherwise available to a claimant under state law or common law in proceedings where one or more defendants is not an officer or employee of the state or any agency of the state.

6. The limitation on awards for noneconomic damages provided for in this subsection shall be increased or decreased on an annual basis effective January first of each year in accordance with the Implicit Price Deflator for Personal Consumption Expenditures as published by the Bureau of Economic Analysis of the United States Department of Commerce. The current value of the limitation shall be calculated by the director of the department of insurance, who shall furnish that value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021, RSMo.

7. Except as provided in subsection 3 of this section, in the case of any claim or judgment that arises under sections 537.600 and 537.610, RSMo, against the state of Missouri, or an agency of the state, the aggregate of payments from the state legal expense fund and from any policy of insurance procured pursuant to the provisions of section 105.721 shall not exceed the limits of liability as provided in sections 537.600 to 537.610, RSMo. No payment shall be made from the state legal expense fund or any policy of insurance procured with state funds pursuant to section 105.721 unless and until the benefits provided to pay the claim by any other policy of liability insurance have been exhausted.

8. The provisions of section 33.080, RSMo, notwithstanding, any moneys remaining to the credit of the state legal expense fund at the end of an appropriation period shall not be transferred to general revenue.

9. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is promulgated under the authority delegated in sections 105.711 to 105.726 shall become effective only if it has been promulgated pursuant to the provisions of chapter 536, RSMo. Nothing in this section shall be interpreted to repeal or affect the validity of any rule filed or

adopted prior to August 28, 1999, if it fully complied with the provisions of chapter 536, 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, 1999, shall be invalid and void.

135.535. 1. A corporation, limited liability corporation, partnership or sole proprietorship, which moves its operations from outside Missouri or outside a distressed community into a distressed community, or which commences operations in a distressed community on or after January 1, 1999, and in either case has more than seventy-five percent of its employees at the facility in the distressed community, and which has fewer than one hundred employees for whom payroll taxes are paid, and which is a manufacturing, biomedical, medical devices, scientific research, animal research, computer software design or development, computer programming, including Internet, web hosting, and other information technology, wireless or wired or other telecommunications or a professional firm shall receive a forty percent credit against income taxes owed pursuant to chapter 143, 147 or 148, RSMo, other than taxes withheld pursuant to sections 143.191 to 143.265, RSMo, for each of the three years after such move, if approved by the department of economic development, which shall issue a certificate of eligibility if the department determines that the taxpayer is eligible for such credit. The maximum amount of credits per taxpayer set forth in this subsection shall not exceed one hundred twenty-five thousand dollars for each of the three years for which the credit is claimed. The department of economic development, by means of rule or regulation promulgated pursuant to the provisions of chapter 536, RSMo, shall assign appropriate North American Industry Classification System numbers to the companies which are eligible for the tax credits provided for in this section. Such three-year credits shall be awarded only one time to any company which moves its operations from outside of Missouri or outside of a distressed community into a distressed community or to a company which commences operations within a distressed community. A taxpayer shall file an application for certification of the tax credits for the first year in which credits are claimed and for each of the two succeeding taxable years for which credits are claimed.

2. Employees of such facilities physically working and earning wages for that work within a distressed community whose employers have been approved for tax credits pursuant to subsection 1 of this section by the department of economic development for whom payroll taxes are paid shall also be eligible to receive a tax credit against individual income tax, imposed pursuant to chapter 143, RSMo, equal to one and one-half percent of their gross salary paid at such facility earned for each of the three years that the facility receives the tax credit provided by this section, so long as they were qualified employees of such entity. The employer shall

calculate the amount of such credit and shall report the amount to the employee and the department of revenue.

3. A tax credit against income taxes owed pursuant to chapter 143, 147 or 148, RSMo, other than the taxes withheld pursuant to sections 143.191 to 143.265, RSMo, in lieu of the credit against income taxes as provided in subsection 1 of this section, may be taken by such an entity in a distressed community in an amount of forty percent of the amount of funds expended for computer equipment and its maintenance, medical laboratories and equipment, research laboratory equipment, manufacturing equipment, fiber optic equipment, high speed telecommunications, wiring or software development expense up to a maximum of seventy-five thousand dollars in tax credits for such equipment or expense per year per entity and for each of three years after commencement in or moving operations into a distressed community.

4. A corporation, partnership or sole partnership, which has no more than one hundred employees for whom payroll taxes are paid, which is already located in a distressed community and which expends funds for such equipment pursuant to subsection 3 of this section in an amount exceeding its average of the prior two years for such equipment, shall be eligible to receive a tax credit against income taxes owed pursuant to chapters 143, 147 and 148, RSMo, in an amount equal to the lesser of seventy-five thousand dollars or twenty-five percent of the funds expended for such additional equipment per such entity. Tax credits allowed pursuant to this subsection or subsection 1 of this section may be carried back to any of the three prior tax years and carried forward to any of the five tax years.

5. An existing corporation, partnership or sole proprietorship that is located within a distressed community and that relocates employees from another facility outside of the distressed community to its facility within the distressed community, and an existing business located within a distressed community that hires new employees for that facility may both be eligible for the tax credits allowed by subsections 1 and 3 of this section. To be eligible for such tax credits, such a business, during one of its tax years, shall employ within a distressed community at least twice as many employees as were employed at the beginning of that tax year. A business hiring employees shall have no more than one hundred employees before the addition of the new employees. This subsection shall only apply to a business which is a manufacturing, biomedical, medical devices, scientific research, animal research, computer software design or development, computer programming or telecommunications business, or a professional firm.

6. Tax credits shall be approved for applicants meeting the requirements of this section in the order that such applications are received. Certificates of tax credits issued in accordance with this section may be transferred, sold or assigned by notarized endorsement which names the transferee.

7. The tax credits allowed pursuant to subsections 1, 2, 3, 4 and 5 of this section shall be for an amount of no more than ten million dollars for each year beginning in 1999. To the extent there are available tax credits remaining under the ten million dollar cap provided in this section, **[**up to one hundred thousand dollars in the**]** **such** remaining credits shall first be used for tax credits authorized under section 135.562. The total maximum credit for all entities already located in distressed communities and claiming credits pursuant to subsection 4 of this section shall be seven hundred and fifty thousand dollars. The department of economic development in approving taxpayers for the credit as provided for in subsection 6 of this section shall use information provided by the department of revenue regarding taxes paid in the previous year, or projected taxes for those entities newly established in the state, as the method of determining when this maximum will be reached and shall maintain a record of the order of approval. Any tax credit not used in the period for which the credit was approved may be carried over until the full credit has been allowed.

8. A Missouri employer relocating into a distressed community and having employees covered by a collective bargaining agreement at the facility from which it is relocating shall not be eligible for the credits in subsection 1, 3, 4 or 5 of this section, and its employees shall not be eligible for the credit in subsection 2 of this section if the relocation violates or terminates a collective bargaining agreement covering employees at the facility, unless the affected collective bargaining unit concurs with the move.

9. Notwithstanding any provision of law to the contrary, no taxpayer shall earn the tax credits allowed in this section and the tax credits otherwise allowed in section 135.110, or the tax credits, exemptions, and refund otherwise allowed in sections 135.200, 135.220, 135.225 and 135.245, respectively, for the same business for the same tax period.

135.562. 1. If any taxpayer with a federal adjusted gross income of thirty thousand dollars or less incurs costs for the purpose of making all or any portion of such taxpayer's principal dwelling accessible to an individual with a disability **or a senior** who permanently resides with the taxpayer, such taxpayer shall receive a tax credit against such taxpayer's Missouri income tax liability in an amount equal to the lesser of one hundred percent of such costs or two thousand five hundred dollars per taxpayer, per tax year. **For purposes of this section, "disability" shall have the same meaning as such term is defined in section 135.010 and "senior" shall mean a person sixty-five years of age or older.**

2. Any taxpayer with a federal adjusted gross income greater than thirty thousand dollars but less than sixty thousand dollars who incurs costs for the purpose of making all or any portion of such taxpayer's principal dwelling accessible to an individual with a disability **or senior** who permanently resides with the taxpayer shall receive a tax credit against such taxpayer's Missouri income tax liability in an amount equal to the lesser of fifty percent of such costs or two thousand

five hundred dollars per taxpayer per tax year. No taxpayer shall be eligible to receive tax credits under this section in any tax year immediately following a tax year in which such taxpayer received tax credits under the provisions of this section.

3. Tax credits issued pursuant to this section may be refundable in an amount not to exceed two thousand five hundred dollars per tax year.

4. Eligible costs for which the credit may be claimed include:

(1) Constructing entrance or exit ramps;

(2) Widening exterior or interior doorways;

(3) Widening hallways;

(4) Installing handrails or grab bars;

(5) Moving electrical outlets and switches;

(6) Installing stairway lifts;

(7) Installing or modifying fire alarms, smoke detectors, and other alerting systems;

(8) Modifying hardware of doors; **[**or**]**

(9) Modifying bathrooms**; or**

(10) Constructing additional rooms in the dwelling or structures on the property for the purpose of accommodating the senior or person with disability.

5. The tax credits allowed, including the maximum amount that may be claimed, pursuant to this section shall be reduced by an amount sufficient to offset any amount of such costs a taxpayer has already deducted from such taxpayer's federal adjusted gross income or to the extent such taxpayer has applied any other state or federal income tax credit to such costs.

6. A taxpayer shall claim a credit allowed by this section in the same taxable year as the credit is issued, and at the time such taxpayer files his or her Missouri income tax return; provided that such return is timely filed.

7. The department may, in consultation with the department of social services, promulgate such rules or regulations as are necessary to administer 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, 2007, shall be invalid and void.

8. The provisions of this section shall apply to all tax years beginning on or after January 1, 2008.

9. The provisions of this section shall expire December 31, 2013.

10. In no event shall the aggregate amount of all tax credits allowed pursuant to this section exceed **[**one hundred thousand dollars**]** **the amount of tax credits remaining unused under the program authorized under section 135.535** in any given fiscal year. The tax credits issued pursuant to this section shall be on a first-come, first-served filing basis.

143.111. The Missouri taxable income of a resident shall be such resident's Missouri adjusted gross income less:

(1) Either the Missouri standard deduction or the Missouri itemized deduction;

(2) The Missouri deduction for personal exemptions;

(3) The Missouri deduction for dependency exemptions; **and**

(4) The deduction for federal income taxes provided in section 143.171**[**; and

(5) The deduction for a self-employed individual's health insurance costs provided in section 143.113**]**.

143.782. As used in sections 143.782 to 143.788, unless the context clearly requires otherwise, the following terms shall mean and include:

(1) "Court", the supreme court, court of appeals, or any circuit court of the state;

(2) "Debt", any sum due and legally owed to any state agency which has accrued through contract, subrogation, tort, or operation of law regardless of whether there is an outstanding judgment for that sum, court costs as defined in section 488.010, RSMo, fines and fees owed, or any support obligation which is being enforced by the **family support** division **[**of family services**]** on behalf of a person who is receiving support enforcement services pursuant to section 454.425, RSMo**[**, or any claim for unpaid health care services which is being enforced by the department of health and senior services on behalf of a hospital or health care provider under section 143.790**]**;

(3) "Debtor", any individual, sole proprietorship, partnership, corporation or other legal entity owing a debt;

(4) "Department", the department of revenue of the state of Missouri;

(5) "Refund", the Missouri income tax refund which the department determines to be due any taxpayer pursuant to the provisions of this chapter. The amount of a refund shall not include any senior citizens property tax credit provided by sections 135.010 to 135.035, RSMo, unless such refund is being offset for a delinquency or debt relating to individual income tax or a property tax credit; and

(6) "State agency", any department, division, board, commission, office, or other agency of the state of Missouri, including public community college districts and housing authorities as defined in section 99.020, RSMo.

143.790. 1. Any hospital or health care provider who has provided health care services to an individual who was not covered by a health insurance policy or was not eligible to receive benefits under the state's medical assistance program of needy persons, Title XIX, P.L. 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301, et seq., under chapter 208, RSMo, and the health insurance for uninsured children under sections 208.631 to 208.657, RSMo, at the time such health care services were administered, and such person has failed to pay for such services for a period greater than ninety days, may submit a claim to the director of the department of **[**health and senior services**] revenue** for the unpaid health care services**[**. The director of the department of health and senior services shall review such claim. If the claim appears meritorious on its face, the claim for the unpaid medical services shall constitute a debt of the department of health and senior services for purposes of sections 143.782 to 143.788, and the director may certify the debt to the department of revenue in order to set off the debtor's income tax refund. Once the debt has been certified, the director of the department of health and senior services shall submit the debt to the department of revenue under the setoff procedure established under section 143.783**] on a claim form approved by the director of revenue**.

2. **The director of revenue shall promulgate a claim form for a hospital or health care provider to certify the following:**

(1) That the hospital or health care provider provided health care services to an individual who was not covered by a health insurance policy or was not eligible to receive benefits under the state's medical assistance program for needy persons, Title XIX, P.L. 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301 et seq., under chapter 208, RSMo, and the children's health insurance program under sections 208.631 to 208.637, RSMo, at the time such health care services were administered;

(2) That such person failed to pay for such services for a period of time greater than one hundred eighty days;

(3) That the amounts billed were the true and accurate charges for the health care services provided to the individual; and

(4) That the hospital or health care provider has made reasonable attempts to notify the individual of the amounts due and has received no assurance of payment from the individual or that the individual has failed to pay the amounts due after notice and an opportunity for payment.

Such certification shall be attested to under penalty of perjury by the hospital or health care provider.

3. At the time of certification, the **[**director of the department of health and senior services**] hospital or health care provider** shall supply any information necessary to identify each debtor whose refund is sought to be set off pursuant to section 143.784 and certify the amount of the debt or debts owed by each such debtor.

[3.**] 4.** If a debtor identified by the **[**director of the department of health and senior services**] hospital or health care provider** is determined by the department of revenue to be entitled to a refund, the department of revenue shall notify the **[**department of health and senior services**] hospital or health care provider** that a refund has been set off on behalf of the **[**department of health and senior services**] hospital or health care provider** for purposes of this section and shall certify the amount of such setoff, which shall not exceed the amount of the claimed debt certified. When the refund owed exceeds the claimed debt, the department shall send the excess amount to the debtor within a reasonable time after such excess is determined.

[4.**] 5.** The department of revenue shall notify the debtor by certified mail the taxpayer whose refund is sought to be set off that such setoff will be made. The notice shall contain the provisions contained in subsection 3 of section 143.794, including the opportunity for a hearing to contest the setoff provided therein, and shall otherwise substantially comply with the provisions of subsection 3 of section 143.784.

[5.**] 6.** Once a debt has been set off and finally determined under the applicable provisions of sections 143.782 to 143.788, **[**and the department of health and senior services has received the funds transferred from the department of revenue,**]** the department of **[**health and senior services**] revenue** shall settle with each hospital or health care provider for the amounts that the department of revenue set off for such party. At the time of each settlement, each hospital or health care provider shall be charged for administration expenses which shall not exceed twenty percent of the collected amount.

[6.**] 7.** Lottery prize payouts made under section 313.321, RSMo, shall also be subject to the setoff procedures established in this section and any rules and regulations promulgated thereto.

[7.**] 8.** The director of the department of revenue shall have priority to offset any delinquent tax owed to the state of Missouri. Any remaining refund shall be offset to **[**pay a state agency debt or to**] first** meet a child support obligation that is enforced by the **family support** division **[**of family services**]** on behalf of a person who is receiving support enforcement services under section 454.425, RSMo**, and then to pay a state agency debt**.

[8.**] 9.** The director of the department of revenue and the director of the department of **[**health and senior**] social** services shall promulgate rules and regulations necessary to administer 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, 2007, shall be invalid and void.

148.380. 1. Every such company, on or before the first day of March in each year, shall make a return verified by the affidavit of its president and secretary, or other chief officers, to the director of the department of insurance, stating the amount of all direct premiums received by it from policyholders in this state, whether in cash or in notes, during the year ending on the thirty-first day of December, next preceding. Upon receipt of such returns the director of the department of insurance shall verify the same and certify the amount of the tax due from the various companies on the basis and at the rate provided in section 148.370, taking into consideration deductions and credits allowed by law, and shall certify the same to the director of revenue together with the amount of the quarterly installments to be made as provided in subsection 2 of this section, on or before the thirtieth day of April of each year.

2. Beginning January 1, 1983, the amount of the tax due for that calendar year and each succeeding calendar year thereafter shall be paid in four approximately equal estimated quarterly installments, and a fifth reconciling installment. The first four installments shall be based upon the tax for the immediately preceding taxable year ending on the thirty-first day of December, next preceding. The quarterly installments shall be made on the first day of March, the first day of June, the first day of September and the first day of December. Immediately after receiving certification from the director of the department of insurance of the amount of tax due from the various companies, the director of revenue shall notify and assess each company the amount of taxes on its premiums for the calendar year ending on the thirty-first day of December, next preceding. The director of revenue shall also notify and assess each company the amount of the estimated quarterly installments to be made for the calendar year. If the amount of the actual tax due for any year exceeds the total of the installments made for such year, the balance of the tax due shall be paid on the first day of June of the year following, together with the regular quarterly payment due at that time. If the total amount of the tax actually due is less than the total amount of the installments actually paid, the amount by which the amount paid exceeds the amount due shall be credited against the tax for the following year and deducted from the quarterly installment otherwise due on the first day of June. If the March first quarterly installment made by a company is less than the amount assessed by the director of revenue, the difference will be due on June first, but no interest will accrue to the state on the difference unless the amount paid

by the company is less than eighty percent of one-fourth of the total amount of tax assessed by the director of revenue for the immediately preceding taxable year.

3. If the estimated quarterly tax installments are not so paid, the director of revenue shall notify the director of the department of insurance who shall thereupon suspend such delinquent company from the further transaction of business in this state until such taxes shall be paid, and such companies shall be subject to the provisions of sections 148.410 to 148.461.

4. Upon receipt of the money the state treasurer shall receipt one-half thereof into the general revenue fund of the state, and one-half thereof to the credit of the county foreign insurance fund for the purposes set forth in section 148.360. **Beginning in fiscal year 2009 and every fiscal year thereafter, moneys collected under this section in connection with the conduct of business in this state by a health carrier for premiums reported for any health benefit plan insurance products shall be distributed in accordance with section 376.991, RSMo.**

5. As used in this section "health benefit plan" and "health carrier" shall have the same meaning as defined in section 376.1350, RSMo.

191.845. 1. The department of social services may issue, subject to appropriation, a grant in the amount of three hundred and fifty thousand dollars to a local government entity or local health department to be used for the establishment of a study to assess the feasibility of pilot projects in the greater St. Charles area and southeast bootheel areas of the state, at the same time. Any grant awarded under this section shall be matched in equal value by the grant recipient. Grant recipients may match the grant with cash, in-kind services, donations of cash or services, and any other forms of match deemed acceptable by the department. The pilot projects shall have the involvement of the local community health coalition to establish new approaches to expand coverage for the uninsured population in the respective communities and to create healthier populations through a single comprehensive health care plan that is focused on both of the above-named areas of the state.

2. At a minimum, such proposals shall include a plan that:

(1) Is established at the community level;

(2) Will improve population health, create a culture of health, and develop a model for providing one hundred percent health services coverage; and

(3) Provides for the submission of a feasibility study by August 2009 that identifies the infrastructure and resources needed for the implementation of the pilot projects and that analyzes the feasibility of extending the pilot projects or expanding the project state-wide.

191.1005. 1. For purposes of this section, "insurer" shall have the same meaning as the term "health carrier" is defined in section 376.1350, RSMo, and includes the state of Missouri for purposes of the rendering of health care services by providers under a medical assistance program of the state.

2. Programs of insurers that publicly assess and compare the quality and cost efficiency of health care providers shall conform to the following criteria:

(1) The insurers shall retain, at their own expense, the services of a nationally-recognized independent health care quality standard-setting organization to review the plan's programs for consumers that measure, report, and tier providers based on their performance. Such review shall include a comparison to national standards and a report detailing the measures and methodologies used by the health plan. The scope of the review shall encompass all elements described in this section and section 191.1008;

(2) The program measures shall provide performance information that reflects consumers' health needs. Programs shall clearly describe the extent to which they encompass particular areas of care, including primary care and other areas of specialty care;

(3) Performance reporting for consumers shall include both quality and cost efficiency information. While quality information may be reported in the absence of cost efficiency, cost efficiency information shall not be reported without accompanying quality information unless the cost provided is related to a discrete service, diagnostic test or procedure;

(4) When any individual measures or groups of measures are combined, the individual scores, proportionate weighting, and any other formula used to develop composite scores shall be disclosed. Such disclosure shall be done both when quality measures are combined and when quality and cost efficiency are combined;

(5) Consumers or consumer organizations shall be solicited to provide input on the program, including methods used to determine performance strata;

(6) A clearly defined process for receiving and resolving consumer complaints shall be a component of any program;

(7) Performance information presented to consumers shall include context, discussion of data limitations, and guidance on how to consider other factors in choosing a provider;

(8) Relevant providers and provider organizations shall be solicited to provide input on the program, including the methods used to determine performance strata;

(9) Providers shall be given reasonable prior notice before their individual performance information is publicly released;

(10) A clearly defined process for providers to request review of their own performance results and the opportunity to present information that supports what they believe to be inaccurate results, within a reasonable time frame, shall be a component of any program. Results determined to be inaccurate after the reconsideration process shall be corrected;

(11) Information about the comparative performance of providers shall be accessible and understandable to consumers and providers;

(12) Information about factors that might limit the usefulness of results shall be publicly disclosed;

(13) Measures used to assess provider performance and the methodology used to calculate scores or determine rankings shall be published and made readily available to the public. Some elements shall be assessed against national standards. Examples of measurement elements that shall be assessed against national standards include: risk and severity adjustment, minimum observations, and statistical standards utilized. Examples of other measurement elements that shall be fully disclosed include: data used, how providers' patients are identified, measure specifications and methodologies, known limitations of the data, and how episodes are defined;

(14) The rationale and methodologies supporting the unit of analysis reported shall be clearly articulated, including a group practice model versus the individual provider;

(15) Sponsors of provider measurement and reporting shall work collaboratively to aggregate data whenever feasible to enhance its consistency, accuracy, and use. Sponsors of provider measurement and reporting shall also work collaboratively to align and harmonize measures used to promote consistency and reduce the burden of collection. The nature and scope of such efforts shall be publicly reported;

(16) The program shall be regularly evaluated to assess its effectiveness and any unintended consequences;

(17) Measures shall be based on national standards. The primary source shall be measures endorsed by the National Quality Forum (NQF). When non-NQF measures are used because NQF measures do not exist or are unduly burdensome, it shall be with the understanding that they will be replaced by comparable NQF-endorsed measures when available;

(18) Where NQF-endorsed measures do not exist, the next level of measures to be considered, to the extent practical, shall be those endorsed by the Ambulatory Quality Alliance (AQA), national accrediting organizations such as the National Committee for Quality Assurance (NCQA), or the Joint Commission and federal agencies;

(19) Supplemental measures are permitted if they address areas of measurement for which national standards do not yet exist or for which existing national standard measure requirements are unreasonably burdensome on providers or program sponsors. Supplemental measures may be used if they are part of a pilot program to assess the extent to which the measures could fill national gaps in measurement. When supplemental measures are used they shall reasonably adhere to the NQF measure criteria, including importance, scientific acceptability, feasibility and usability, and may include sources such as provider specialty society guidelines.

3. The use by an insurer of a program to publicly assess and compare the quality and cost efficiency of health care providers under subsection 2 of this section shall not be a basis for a provider to decline to enter into a provider contract with an insurer. A provider shall not withhold or otherwise obstruct an insurer from using data collected from medical claims or other sources generated by the provider and in possession of the insurer for the purpose of providing plan enrollees, providers, or the public information on the quality and cost efficiency differences in treatments and providers as long as the data is not used in a manner that violates any provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) or antitrust law.

191.1008. 1. Any person who sells or otherwise distributes to the public health care quality and cost efficiency data for disclosure in comparative format to the public shall identify the measure source or evidence-based science behind the measure and the national consensus, multi-stakeholder, or other peer review process, if any, used to confirm the validity of the data and its analysis as an objective indicator of health care quality.

2. Quality of care data published by state and local government agencies and articles or research studies on the topic of health care quality or cost efficiency that are published in peer-reviewed academic journals or by nonprofit community-based organizations shall be exempt from the requirements of subsection 1 of this section.

3. (1) Upon receipt of a complaint of an alleged violation of this section by a person or entity other than a health carrier, the department of health and senior services shall investigate the complaint and, upon finding that a violation has occurred, shall be authorized to impose a penalty in an amount not to exceed one thousand dollars. The department shall promulgate rules governing its processes for conducting such investigations and levying fines authorized by law.

(2) 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, 2008, shall be invalid and void.

191.1010. All alleged violations of sections 191.1005 to 191.1008 by a health insurer shall be investigated and enforced by the department of insurance, financial institutions and professional registration under the department's powers and responsibilities to enforce the insurance laws of this state in accordance with chapter 374, RSMo.

191.1200. 1. The general assembly may appropriate four hundred thousand dollars from the health care technology fund created in section 208.975, RSMo, to the department of social services for the purpose of awarding a grant to implement an Internet web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room. The grantee shall establish a program that diverts patients presenting at an emergency room for nonemergency care to more appropriate outpatient settings as is consistent with federal law and regulations. The program shall refer the patient to an appropriate health care professional based on the patient's health care needs and situation. The program shall provide the patient with a scheduled appointment that is timely, with an appropriate provider who is conveniently located. If the patient is uninsured and potentially eligible for MO HealthNet, the program shall connect the patient to a primary care provider, community clinic, or agency that can assist the patient with the application process. The program shall also ensure that discharged patients are connected with a community-based primary care provider and assist in scheduling any necessary follow-up visits before the patient is discharged.

2. The program shall not require a provider to pay a fee for accepting charity care patients in a Missouri public health care program.

3. The grantee shall report to the director on a quarterly basis the following information:

(1) The total number of appointments available for scheduling by specialty;

(2) The average length of time between scheduling and actual appointment;

(3) The total number of patients referred and whether the patient was insured or uninsured; and

(4) The total number of appointments resulting in visits completed and number of patients continuing services with the referring clinic.

4. The director, in consultation with the Missouri Hospital Association, or a successor organization, shall conduct an evaluation of the emergency room diversion pilot

project and submit the results to the general assembly by January 15, 2009. The evaluation shall compare the number of nonemergency visits and repeat visits to hospital emergency rooms for the period before the commencement of the project and one year after the commencement, and an estimate of the costs saved from any documented reductions.

191.1250. As used in sections 191.1250 to 191.1271, the following terms shall mean:

(1) "Chronic condition", any regularly recurring, potentially life-threatening medical condition that requires regular supervision by a primary care physician and/or medical specialist;

(2) "Department", the department of health and senior services;

(3) "EMR" or "electronic medical record", refers to a patient's medical history that is stored in real-time using information technology and which can be amended, updated, or supplemented by the patient or the physician using the electronic medical record;

(4) "HIPAA", the federal Health Insurance Portability and Accountability Act of 1996;

(5) "Originating site", a place where a patient may receive health care via telehealth. An originating site may include:

(a) A licensed inpatient center;

(b) An ambulatory surgical center;

(c) Any practice location, office, or clinic of a licensed health care professional;

(d) A skilled nursing facility;

(e) A residential treatment facility;

(f) A home health agency;

(g) A diagnostic laboratory or imaging center;

(h) An assisted living facility;

(i) A school-based health program;

(j) A mobile clinic;

(k) A mental health clinic;

(l) A rehabilitation or other therapeutic health setting;

(m) The patient's residence;

(n) The patient's place of employment; or

(o) The patient's then-current location if the patient is away from the patient's residence or place of employment;

(6) "Telehealth", the use of telephonic and other electronic means of communications to provide and support health care delivery, diagnosis, consultation, and treatment when distance separates the patient and the health care provider;

(7) "Telehealth practitioner", a person who is a licensed health care professional and who utilizes telehealth to diagnose, consult with, or treat patients without having conducted an in-person consultation with a particular patient.

191.1256. Sections 191.1250 to 191.1271 do not:

(1) Alter the scope of practice of any health care practitioner; or

(2) Limit a patient's right to choose in-person contact with a health care practitioner for the delivery of health care services for which telehealth is available.

191.1259. The delivery of health care via telehealth is recognized and encouraged as a safe, practical and necessary practice in this state. No health care provider or operator of an originating site shall be disciplined for or discouraged from participating in sections 191.1250 to 191.1271. In using telehealth procedures, health care providers and operators of originating sites shall comply with all applicable federal and state guidelines and shall follow established federal and state rules regarding security, confidentiality and privacy protections for health care information.

191.1265. Only telehealth practitioners qualified under sections 191.1250 to 191.1271 may practice telehealth care in this state. Telehealth practitioners may reside outside this state but shall be licensed by an appropriate board within the division of professional registration. The department shall establish a two-year pilot project in a rural area of the state that requires all health carriers, as defined in section 376.1350, RSMo, to reimburse services provided through telehealth.

191.1271. By January 1, 2009, the department shall promulgate quality control rules and regulations to be used in removing and improving the services of telehealth practitioners. 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, 2008, shall be invalid and void.

192.083. There is hereby established in the department of health and senior services an "Office of Minority Health". The office of minority health shall monitor the progress of all programs in the department for their impact on eliminating the health status disparity between minorities and the general population and shall:

(1) Address new issues related to minority health;

(2) Instill cultural sensitivity and awareness into all existing programs of the department of health and senior services;

(3) Develop health education programs specifically for minorities;

(4) Promote constituency development;

(5) Coordinate programs provided by other agencies;

(6) Develop culturally sensitive health education materials;

(7) Seek extramural funding for programs;

(8) Develop resources within communities **through solicitation of proposals from community programs and organizations representing minorities to develop culturally-appropriate solutions and services relating to health and wellness**;

(9) Establish interagency communication to assure that agreements are established and carried out;

(10) Ensure that personnel within the department of health and senior services have cultural understanding and sensitivity;

(11) Ensure that all programs are designed to be responsive to unique needs of minorities;

(12) Provide necessary health and medical information, data, and staff resources to the Missouri minority health issues task force;

(13) Review all programs of the department, their impact on the health status of minorities;

(14) Assist in the design of programs targeted specifically to improving the health of minorities;

(15) Develop programs that can attract other public and private funds;

(16) Analyze federal and state legislation for its impact on the health status of minorities;

(17) Advise the director of the department of health and senior services on health matters that affect minorities;

(18) Coordinate the development of educational programs designed to reduce the incidence of disease in the minority population**; and**

(19) Solicit proposals from faith-based organizations on initiatives to educate minorities on the value of personal responsibility and wellness.

192.990. 1. To support the successful and growing collaboration of community volunteers and pro bono services by providers throughout Missouri in meeting the primary care health needs of many uninsured people in the state, there is created the "Missouri Free Clinics Fund" to be administered by the department of social services for use by clinics in the Missouri free clinics association, or any successor organization. For a one-time funding appropriation of five hundred thousand dollars from the general assembly,

subject to appropriation, the department shall disburse funds to the association to be equitably and evenly distributed to all free clinics in the state, in accordance with applicable guidelines, policies, and requirements established by the department to add services into existing clinics. Grant support will be limited to capacity building projects for existing clinics. No more than three percent of the funds shall be used by the association for administration of the funds.

2. For purposes of this section, "capacity building projects" means activities that improve an organization's ability to achieve its mission by providing existing clinics an opportunity to increase their infrastructure and bolster their sustainability in order to serve a greater number of people in a more effective manner. Such activities may include efforts to improve a clinic's ability to deliver services by covering operating expenses, sustaining or increasing service levels, or stabilizing finances.

3. The state treasurer shall be custodian of the fund and may approve disbursements from the fund in accordance with sections 30.170 and 30.180, RSMo.

4. The department shall promulgate rules setting forth the procedures and methods for 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, 2008, shall be invalid and void.

5. 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. 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.

196.1200. 1. There is hereby established in the state treasury the "Tobacco Use Prevention and Cessation Trust Fund" to be held separate and apart from all other public moneys and funds of the state, including but not limited to the tobacco securitization settlement trust fund established in section 8.550, RSMo. The state treasurer shall deposit into the fund the first five million dollars received from the strategic contribution payments received from the account provided under subsection IX(c)(2) of the master settlement agreement, as defined in section 196.1000, beginning in fiscal year 2009 and in perpetuity

thereafter. All moneys in the fund shall be used for the purposes of this section only. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, the moneys in the fund shall not revert to the credit of general revenue at the end of the biennium.

2. Moneys in the tobacco use prevention and cessation trust fund shall be used strategically, in cooperation with other governmental and not-for-profit entities, for a comprehensive tobacco control program for the purpose of tobacco prevention and cessation. At least twenty-five percent of the moneys from the fund shall be used for youth smoking prevention programs modeled upon evidence-based programs proven to reduce youth smoking in one or more jurisdictions within the United States.

3. Moneys shall be allocated consistently with the Center for Disease Control and Prevention, or it successor agency's, best practices and guidelines for state tobacco control programs and as determined by the department of health and senior services.

4. The department of health and senior services shall promulgate such rules and regulations as are necessary to implement 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, 2008, shall be invalid and void.

197.305. As used in sections 197.300 to 197.366, the following terms mean:

(1) "Affected persons", the person proposing the development of a new institutional health service, the public to be served, and health care facilities within the service area in which the proposed new health care service is to be developed;

(2) "Agency", the certificate of need program of the Missouri department of health and senior services;

(3) "Capital expenditure", an expenditure by or on behalf of a health care facility which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance;

(4) "Certificate of need", a written certificate issued by the committee setting forth the committee's affirmative finding that a proposed project sufficiently satisfies the criteria prescribed for such projects by sections 197.300 to 197.366;

(5) "Develop", to undertake those activities which on their completion will result in the offering of a new institutional health service or the incurring of a financial obligation in relation to the offering of such a service;

(6) "Expenditure minimum" shall mean:

(a) For beds in existing or proposed health care facilities licensed pursuant to chapter 198, RSMo, and long-term care beds in a hospital as described in subdivision (3) of subsection 1 of section 198.012, RSMo, six hundred thousand dollars in the case of capital expenditures, or four hundred thousand dollars in the case of major medical equipment**[**, provided, however, that prior to January 1, 2003, the expenditure minimum for beds in such a facility and long-term care beds in a hospital described in section 198.012, RSMo, shall be zero, subject to the provisions of subsection 7 of section 197.318**]**;

(b) For beds or equipment in a long-term care hospital meeting the requirements described in 42 CFR, Section 412.23(e), the expenditure minimum shall be zero; and

(c) For health care facilities, new institutional health services or beds not described in paragraph (a) or (b) of this subdivision one million dollars in the case of capital expenditures, excluding major medical equipment, and one million **five hundred thousand** dollars in the case of medical equipment;

(7) "Health care facilities", hospitals, health maintenance organizations, tuberculosis hospitals, psychiatric hospitals, intermediate care facilities, skilled nursing facilities, residential care facilities and assisted living facilities, kidney disease treatment centers, including freestanding hemodialysis units, diagnostic imaging centers, radiation therapy centers and ambulatory surgical facilities, but excluding the private offices of physicians, dentists and other practitioners of the healing arts, and Christian Science sanatoriums, also known as Christian Science Nursing facilities listed and certified by the Commission for Accreditation of Christian Science Nursing Organization/Facilities, Inc., and facilities of not-for-profit corporations in existence on October 1, 1980, subject either to the provisions and regulations of Section 302 of the Labor-Management Relations Act, 29 U.S.C. 186 or the Labor-Management Reporting and Disclosure Act, 29 U.S.C. 401-538, and any residential care facility or assisted living facility operated by a religious organization qualified pursuant to Section 501(c)(3) of the federal Internal Revenue Code, as amended, which does not require the expenditure of public funds for purchase or operation, with a total licensed bed capacity of one hundred beds or fewer;

(8) "Health service area", a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources, consisting of a population of not less than five hundred thousand or more than three million;

(9) "Major medical equipment", medical equipment used for the provision of medical and other health services;

(10) "New institutional health service":

(a) The development of a new health care facility costing in excess of the applicable expenditure minimum;

(b) The acquisition, including acquisition by lease, of any health care facility, or major medical equipment costing in excess of the expenditure minimum;

(c) Any capital expenditure by or on behalf of a health care facility in excess of the expenditure minimum;

(d) Predevelopment activities as defined in subdivision (13) hereof costing in excess of one hundred fifty thousand dollars;

(e) Any change in licensed bed capacity of a health care facility which increases the total number of beds by more than ten or more than ten percent of total bed capacity, whichever is less, over a two-year period;

(f) Health services, excluding home health services, which are offered in a health care facility and which were not offered on a regular basis in such health care facility within the twelve-month period prior to the time such services would be offered;

(g) A reallocation by an existing health care facility of licensed beds among major types of service or reallocation of licensed beds from one physical facility or site to another by more than ten beds or more than ten percent of total licensed bed capacity, whichever is less, over a two-year period;

(11) "Nonsubstantive projects", projects which do not involve the addition, replacement, modernization or conversion of beds or the provision of a new health service but which include a capital expenditure which exceeds the expenditure minimum and are due to an act of God or a normal consequence of maintaining health care services, facility or equipment;

(12) "Person", any individual, trust, estate, partnership, corporation, including associations and joint stock companies, state or political subdivision or instrumentality thereof, including a municipal corporation;

(13) "Predevelopment activities", expenditures for architectural designs, plans, working drawings and specifications, and any arrangement or commitment made for financing; but excluding submission of an application for a certificate of need.

197.310. 1. The "Missouri Health Facilities Review Committee" is hereby established. The agency shall provide clerical and administrative support to the committee. The committee may employ additional staff as it deems necessary.

2. The committee shall be composed of:

(1) Two members of the senate appointed by the president pro tem, who shall be from different political parties; and

(2) Two members of the house of representatives appointed by the speaker, who shall be from different political parties; and

(3) Five members **who are consumers of health care services, who shall be** appointed by the governor with the advice and consent of the senate, not more than three of whom shall be from the same political party.

No member of the committee shall be directly or indirectly employed or associated with a health facility that is regulated under sections 197.300 to 197.366. The provisions of sections 105.452 to 105.458, RSMo, prohibiting conflicts of interest shall apply to all committee members. In the event any member has an actual or potential conflict of interest with regard to any party to a pending application, such member shall be recused from participating in the proceeding.

3. No business of this committee shall be performed without a majority of the full body.

4. **[**The members shall be appointed as soon as possible after September 28, 1979. One of the senate members, one of the house members and three of the members appointed by the governor shall serve until January 1, 1981, and the remaining members shall serve until January 1, 1982.**]** All **[**subsequent**]** members shall be appointed in the manner provided in subsection 2 of this section and shall serve terms of two years.

5. The committee shall elect a chairman at its first meeting which shall be called by the governor. The committee shall meet upon the call of the chairman or the governor.

6. The committee shall review and approve or disapprove all applications for a certificate of need made under sections 197.300 to 197.366. It shall issue reasonable rules and regulations governing the submission, review and disposition of applications.

7. Members of the committee shall serve without compensation but shall be reimbursed for necessary expenses incurred in the performance of their duties.

8. Notwithstanding the provisions of subsection 4 of section 610.025, RSMo, the proceedings and records of the facilities review committee shall be subject to the provisions of chapter 610, RSMo.

197.315. 1. Any person who proposes to develop or offer a new institutional health service within the state must obtain a certificate of need from the committee prior to the time such services are offered.

2. Only those new institutional health services which are found by the committee **upon a preponderance of the evidence** to be needed shall be granted a certificate of need. Only those new institutional health services which are granted certificates of need shall be offered or

developed within the state. No expenditures for new institutional health services in excess of the applicable expenditure minimum shall be made by any person unless a certificate of need has been granted.

3. After October 1, 1980, no state agency charged by statute to license or certify health care facilities shall issue a license to or certify any such facility, or distinct part of such facility, that is developed without obtaining a certificate of need.

4. If any person proposes to develop any new institutional health care service without a certificate of need as required by sections 197.300 to 197.366, the committee shall notify the attorney general, and he shall apply for an injunction or other appropriate legal action in any court of this state against that person.

5. After October 1, 1980, no agency of state government may appropriate or grant funds to or make payment of any funds to any person or health care facility which has not first obtained every certificate of need required pursuant to sections 197.300 to 197.366.

6. A certificate of need shall be issued only for the premises and persons named in the application and is not transferable except by consent of the committee.

7. Project cost increases, due to changes in the project application as approved or due to project change orders, exceeding the initial estimate by more than ten percent shall not be incurred without consent of the committee.

8. Periodic reports to the committee shall be required of any applicant who has been granted a certificate of need until the project has been completed. The committee may order the forfeiture of the certificate of need upon failure of the applicant to file any such report.

9. A certificate of need shall be subject to forfeiture for failure to incur a capital expenditure on any approved project within six months after the date of the order. The applicant may request an extension from the committee of not more than six additional months based upon substantial expenditure made.

10. Each application for a certificate of need must be accompanied by an application fee. The time of filing commences with the receipt of the application and the application fee. The application fee is one thousand dollars, or one-tenth of one percent of the total cost of the proposed project, whichever is greater**, but such fee shall not exceed five thousand dollars for new equipment, and shall not exceed twenty-five thousand dollars for new health care facilities**. All application fees shall be deposited in the state treasury. Because of the loss of federal funds, the general assembly will appropriate funds to the Missouri health facilities review committee.

11. In determining whether a certificate of need should be granted, no consideration shall be given to the facilities or equipment of any other health care facility located more than a fifteen-mile radius from the applying facility.

12. When a nursing facility shifts from a skilled to an intermediate level of nursing care, it may return to the higher level of care if it meets the licensure requirements, without obtaining a certificate of need.

13. In no event shall a certificate of need be denied because the applicant refuses to provide abortion services or information.

14. A certificate of need shall not be required for the transfer of ownership of an existing and operational health facility in its entirety.

15. A certificate of need may be granted to a facility for an expansion, an addition of services, a new institutional service, or for a new hospital facility which provides for something less than that which was sought in the application.

16. The provisions of this section shall not apply to facilities operated by the state, and appropriation of funds to such facilities by the general assembly shall be deemed in compliance with this section, and such facilities shall be deemed to have received an appropriate certificate of need without payment of any fee or charge.

17. Notwithstanding other provisions of this section, a certificate of need may be issued after July 1, 1983, for an intermediate care facility operated exclusively for the mentally retarded.

18. To assure the safe, appropriate, and cost-effective transfer of new medical technology throughout the state, a certificate of need shall not be required for the purchase and operation of research equipment that is to be used in a clinical trial that has received written approval from a duly constituted institutional review board of an accredited school of medicine or osteopathy located in Missouri to establish its safety and efficacy and does not increase the bed complement of the institution in which the equipment is to be located. After the clinical trial has been completed, a certificate of need must be obtained for continued use in such facility.

19. Prior to the initial hearing of an application, any health care provider who is in opposition to such application pending before the committee shall file a written statement in opposition, and shall further provide to the applicant and all other parties of record for such proceeding a complete copy of such statement.

197.330. 1. The committee shall:

(1) Notify the applicant within fifteen days of the date of filing of an application as to the completeness of such application;

(2) Provide written notification to affected persons located within this state at the beginning of a review. This notification may be given through publication of the review schedule in all newspapers of general circulation in the area to be served;

(3) **Within thirty days from the date of publication of the notification of review,** hold public hearings on all applications when a request in writing is filed by any affected person **[**within thirty days from the date of publication of the notification of review**] or party**;

(4) Within one hundred days of the filing of any application for a certificate of need, issue in writing its findings of fact, conclusions of law, and its approval or denial of the certificate of need; provided, that the committee may grant an extension of not more than thirty days on its own initiative or upon the written request of any affected person;

(5) Cause to be served upon the applicant, the respective health system agency, and any affected person who has filed his prior request in writing, a copy of the aforesaid findings, conclusions and decisions;

(6) Consider the needs and circumstances of institutions providing training programs for health personnel;

(7) Provide for the availability, based on demonstrated need, of both medical and osteopathic facilities and services to protect the freedom of patient choice; and

(8) Establish by regulation procedures to review, or grant a waiver from review, nonsubstantive projects.

The term "filed" or "filing" as used in this section shall mean delivery to the staff of the health facilities review committee the document or documents the applicant believes constitute an application.

2. Failure by the committee to issue a written decision on an application for a certificate of need within the time required by this section shall constitute approval of and final administrative action on the application, and is subject to appeal pursuant to section 197.335 only on the question of approval by operation of law.

3. For all hearings held by the committee, including all public hearings under subdivision (3) of subsection 1 of this section:

(1) All testimony and other evidence taken during such hearings shall be under oath and subject to the penalty of perjury;

(2) The committee may, upon a majority vote of the committee, exercise subpoena power to compel the production of documents or compel the testimony of witnesses. The power of subpoena, however, shall only be limited to the parties engaged in the proceeding either as an applicant or who have declared their opposition to the application;

(3) There shall be no ex parte communications between members of the committee nor shall there be any ex parte communications by any person or party with committee members regarding the subject matter of any pending application or potential application under sections 197.300 to 197.366. Any member of the committee who participates in an ex parte communication regarding a pending application shall be recused and prohibited from participating in such proceeding;

(4) In all applications or hearings upon applications under sections 197.300 to 197.366, there shall be no presumption in favor of or against the applicant's request for a certificate;

(5) All hearings before the committee shall be governed by rules to be adopted and prescribed by the committee; except that, in all inquiries or hearings, the committee shall not be bound by the technical rules of evidence. No formality of any proceeding nor the manner of taking testimony before the committee shall invalidate any decision made by the committee; and

(6) The committee is authorized to assess all or part of the costs of the proceeding, the applicant's costs, including but not limited to the applicant's reasonable attorney's fees against any health care provider who opposed in writing the application if the committee by a majority vote finds clear and convincing evidence that the party's or parties' opposition to the application was frivolous. For the purpose of this subdivision, "frivolous" means opposition that is without a reasonable basis in fact or law.

197.551. As used in sections 197.551 to 197.587, the following terms shall mean:

(1) "Identifiable information", information that is presented in a form and manner that allows the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information includes any individually identifiable health information, as defined in federal regulations promulgated under Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as amended;

(2) "Nonidentifiable information", information presented in a form and manner that prevents the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information shall be de-identified consistent with the federal regulations promulgated under Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as amended;

(3) "Patient safety organization", any entity which:

(a) Is organized as an independent not-for-profit corporation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and applicable state law governing not-for-profit corporations;

(b) Meets the statutory and regulatory criteria for certification as a patient safety organization under the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended, and regulations promulgated thereunder;

(c) Has a governing board or advisory committee that includes representatives of hospitals, physicians, an employer or group representing employers, an insurance company or group representing insurance companies, the long-term care industry, and a federally

recognized quality improvement organization that contracts with the federal government to review medical necessity and quality assurance in the Medicare program;

(d) Conducts, as the organization's primary activity, efforts to improve patient safety and the quality of health care delivery;

(e) Collects and analyzes patient safety work product that is submitted by providers;

(f) Develops and disseminates evidence-based information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices;

(g) Utilizes patient safety work product to carry out activities limited to those described under this section and for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to providers to effectively minimize patient risk;

(h) Maintains confidentiality with respect to identifiable information pursuant to federal and state law and regulations;

(i) Implements appropriate security measures with respect to patient safety work product;

(j) Submits, if authorized by its governing board and certified by federal law and regulation, nonidentifiable information to a national patient safety database; and

(k) Provides technical support to health care providers in the collection, submission, and analysis of data and patient safety activities as described in sections 197.554 and 197.566;

(4) "Patient safety work product", as defined in federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299h-21, et seq., as amended;

(5) "Provider", as defined in federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended;

(6) "Reportable incident", an occurrence of a serious reportable event in health care as such event is defined in subdivision (9) of this subsection;

(7) "Reportable incident prevention plan", a written plan that:

(a) Defines, based on a root cause analysis, specific changes in organizational policies and procedures designed to reduce the risk of similar incidents occurring in the future or that provides a rationale that no such changes are warranted;

(b) Sets deadlines for the implementation of such changes;

(c) Establishes who is responsible for making the changes; and

(d) Provides a mechanism for evaluating the effectiveness of such changes;

(8) "Root cause analysis", a structured process for identifying basic or causal factors that underlie variation in performance, including but not limited to the occurrence or possible occurrence of a reportable incident. A root cause analysis focuses primarily on systems and processes rather than individual performance and progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines after analysis that no such improvement opportunities existed; and

(9) "Serious reportable event in health care", an occurrence of one or more of the actions or outcomes included in the list of serious adverse events in health care as initially defined by the National Quality Forum in its March 2002 report and subsequently updated by the National Quality Forum, including all criteria established for identifying such events.

197.554. 1. Effective six months after the effective date of initial federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., a hospital shall report each reportable incident to a patient safety organization. The hospital's initial report of the incident shall be submitted to the patient safety organization no later than the close of business on the next business day following discovery of the incident. The initial report shall include a description of immediate actions to be taken by the hospital to minimize the risk of harm to patients and prevent a reoccurrence and verification that the hospital's patient safety and performance improvement review processes are responding to the reportable incident. The hospital shall, within forty-five days after the incident occurs, submit a completed root cause analysis and a reportable incident prevention plan to the patient safety organization.

2. Upon request of the hospital, a patient safety organization may provide technical assistance in the development of a root cause analysis or reportable incident prevention plan relating to a reportable incident.

3. All hospitals shall establish a policy whereby the patient or the patient's legally authorized representative is notified of the occurrence of a serious reportable event in health care as defined in subdivision (10) of section 197.551. Such notification shall be provided not later than seven days after the hospital or its agent becomes aware of the occurrence. The time, date, participants, and content of the notification shall be documented in the patient's medical record. The provision of notice to a patient under this section shall not, in any action or proceeding, be considered an acknowledgment or admission of liability.

197.557. Pursuant to paragraphs (f) and (g) of subdivision (4) of section 197.551 and 42 U.S.C. Section 299b-21, et seq., the patient safety organization shall assess the information provided regarding the reportable incident and furnish the hospital with a report of its findings and recommendations as to how to prevent future incidents.

197.563. 1. The provisions of sections 197.551 to 197.587 shall not be construed to:

(1) Restrict the availability of information gleaned from original sources;

(2) Limit the disclosure or use of information from original sources regarding a reportable incident to:

(a) State or federal agencies or law enforcement under law or regulation; or

(b) Health care facility accreditation agencies.

2. Nothing in sections 197.551 to 197.566 shall modify the duty of a hospital to report disciplinary actions or medical malpractice actions against a health care professional under law.

197.566. 1. The patient safety organization shall publish an annual report to the public on reportable incidents. The first report shall include twelve months of reported data and shall be published not more than fifteen months after the date data collection begins. The report shall indicate the number of reportable events by the then current National Quality Forum category of reportable incident and rate per patient encounter by region and by category of reportable incident, as such categories are established by the National Quality Forum in defining reportable incidents, and may identify reportable incidents by type of facility. The report for the previous year shall be made public no later than April thirtieth. For purposes of the annual report, the state shall be divided into no fewer than three regions, with the St. Louis metropolitan statistical area being one of the regions.

2. The patient safety organization as defined in this section shall report annually to the health policy council created in section 26.859, RSMo.

197.572. No person shall disclose the actions, decisions, proceedings, discussions, or deliberations occurring at a meeting of a patient safety organization except to the extent necessary to carry out one or more of the purposes of a patient safety organization. A meeting of the patient safety organization shall include any meetings of the patient safety organization; its staff; its governing board; any and all committees, work groups, and task forces of the patient safety organization, whether or not formally appointed by the governing board; its president and its chairperson; and any meeting in any setting in which patient safety work product is discussed in the normal course of carrying out the business of the patient safety organization. The proceedings and records of a patient safety organization shall not be subject to discovery or introduction into evidence in any civil

action against a provider arising out of the matter or matters that are the subject of consideration by a patient safety organization. Information, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a patient safety organization. The provisions of this section shall not be construed to prevent a person from testifying to or reporting information obtained independently of the activities of a patient safety organization or which is public information.

197.575. Patient safety work product shall be privileged and confidential pursuant to the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended, and regulations promulgated thereunder.

197.578. 1. Any reference to or offer into evidence in the presence of the jury or other fact-finder or admission into evidence of patient safety work product during any proceeding that is contrary to the provisions of sections 197.551 to 197.587 shall constitute grounds for a mistrial or a similar termination of the proceeding and reversible error on appeal from any judgment or order entered in favor of any party who so discloses or offers into evidence patient safety work product.

2. The prohibition against discovery, disclosure, or admission into evidence of patient safety work product is in addition to any other protections provided by law.

197.581. A patient safety organization may disclose nonidentifiable information and nonidentifiable aggregate trend data identifying the number and types of patient safety events that occur. A patient safety organization shall publish educational and evidence-based information from the summary reports that can be used by all providers to improve the care provided.

197.584. 1. The confidentiality of patient safety work product shall in no way be impaired or otherwise adversely affected solely by reason of the submission of the same to a patient safety organization. The confidentiality of patient safety work product submitted in compliance with sections 197.551 to 197.587 to a patient safety organization shall not be adversely affected if the entity later ceases to meet the statutory definition of a patient safety organization.

2. The exchange or disclosure of patient safety work product by a patient safety organization shall not constitute a waiver of confidentiality or privilege by the health care provider who submitted the data.

197.587. Any provider furnishing services to a patient safety organization shall not be liable for civil damages as a result of such ads, omissions, decisions, or other such conduct in connection with the lawful duties on behalf of a patient safety organization,

except for acts, omissions, decisions, or conduct done with actual malice, fraudulent intent, or bad faith.

197.588. This section shall apply to any hospital that reports a reportable incident under section 197.554. A claim for payment filed by a hospital for health care services related to a reportable incident shall not be subject to sections 375.1000 or 375.383, RSMo.

197.590. 1. Beginning January 1, 2010, any hospital that reports a reportable incident shall not charge for or bill any entity, including third-party payors and patients, for all services related to the reportable incident. If a third-party payor denies a claim, in whole or in part, because there is no coverage for services that resulted in any of the reportable incidents described in this section, the health care professional or facility that provided such services is prohibited from billing the patient for such services.

2. For purposes of this section, "third-party payor" means a health carrier as defined in section 376.1350, RSMo, an organization entering into a preferred provider arrangement, and a third-party administrator for a self-funded health benefit plan.

197.625. 1. As used in this section, the following terms shall mean:

(1) "Lift team", hospital employees specially trained to conduct patient lifts, transfers, and repositioning using lifting equipment when appropriate;

(2) "Musculoskeletal disorders", conditions that involve the nerves, tendons, muscles, and supporting structures of the body;

(3) "Safe patient handling", the use of engineering controls, lifting and transfer aids, or assistive devices, by lift teams or other staff instead of manual lifting, to perform the acts of lifting, transferring, and repositioning health care patients and residents.

2. Any licensed hospital may establish a safe patient handling committee either by creating a new committee or assigning the functions of a safe patient handling committee to an existing committee. The purpose of the committee is to design and recommend the process for implementing a safe patient handling program. At least half of the members of the safe patient handling committee shall be frontline nonmanagerial employees who provide direct care to patients unless doing so would adversely affect patient care.

3. Any licensed hospital may establish a safe patient handling program in accordance with the provisions of this section. As part of the program, each hospital shall:

(1) Implement a safe patient handling policy for all shifts and units of the hospital. Implementation of the safe patient handling policy may be phased-in with the acquisition of equipment under subsection 4 of this section;

(2) Conduct a patient handling hazard assessment. Such assessment shall consider such variables as patient-handling tasks, types of nursing units, patient populations, and the physical environment of patient care areas;

(3) Develop a process to identify the appropriate use of the safe patient handling policy based on the patient's physical and medical condition and the availability of lifting equipment or lift teams. The policy shall include a means to address circumstances under which it would be medically contraindicated to use lifting or transfer aids or assistive devices for particular patients;

(4) Conduct an annual performance evaluation of the program to determine its effectiveness, with the results of the evaluation reported to the safe patient handling committee. The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in musculoskeletal disorder caused by patient handling, and include recommendations to increase the program's effectiveness; and

(5) When developing architectural plans for constructing or remodeling a hospital or a unit of a hospital in which patient handling and movement occurs, consider the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate such equipment at a later date.

4. Two years after establishing a patient safety program under this section, each such hospital shall complete, at a minimum, acquisition of their choice of:

(1) One readily available lift per acute care unit on the same floor unless the safe patient handling committee determines a lift is unnecessary in the unit;

(2) One lift for every ten acute care available patient beds; or

(3) Equipment for use by lift teams.

Hospitals shall train staff on policies, equipment, and devices at least annually.

5. Nothing in this section shall preclude lift team members from performing other duties as assigned during their shift.

6. Each hospital establishing a patient safety program under this section shall develop procedures for hospital employees to refuse to perform or be involved in patient handling or movement that the hospital employee believes in good faith will expose a patient or hospital employee to an unacceptable risk of injury. A hospital employee who in good faith follows the procedure developed by the hospital in accordance with this subsection shall not be the subject of disciplinary action by the hospital for the refusal to perform or be involved in patient handling or movement.

7. Each hospital establishing a patient safety program under this section may apply to the Missouri health and educational facilities authority for low cost loans to acquire their choice of patient handling equipment. The authority may promulgate rules to implement the provisions of this subsection. 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, 2008, shall be invalid and void.

287.055. 1. By January 1, 2010, the division of workers' compensation shall develop rules to provide a reduced workers' compensation premium for hospitals that implement a safe patient handling program in accordance with section 197.625, RSMo. The rules shall include any requirements for obtaining the reduced premium that shall be met by hospitals.

2. The division shall complete an evaluation of the results of the reduced premium, including changes in claim frequency and costs, and shall report to the appropriate committees of the general assembly by December 1, 2013, and 2015.

3. 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, 2008, shall be invalid and void.

313.321. 1. The money received by the Missouri state lottery commission from the sale of Missouri lottery tickets and from all other sources shall be deposited in the "State Lottery Fund", which is hereby created in the state treasury. At least forty-five percent, in the aggregate, of the money received from the sale of Missouri lottery tickets shall be appropriated to the Missouri state lottery commission and shall be used to fund prizes to lottery players. Amounts in the state lottery fund may be appropriated to the Missouri state lottery commission for administration, advertising, promotion, and retailer compensation. The general assembly shall appropriate remaining moneys not previously allocated from the state lottery fund by transferring such moneys to the general revenue fund. The lottery commission shall make monthly transfers of moneys not previously allocated from the state lottery fund to the general revenue fund as provided by appropriation.

2. The commission may also purchase and hold title to any securities issued by the United States government or its agencies and instrumentalities thereof that mature within the term of the prize for funding multi-year payout prizes.

3. The "Missouri State Lottery Imprest Prize Fund" is hereby created. This fund is to be established by the state treasurer and funded by warrants drawn by the office of administration from the state lottery fund in amounts specified by the commission. The commission may write checks and disburse moneys from this fund for the payment of lottery prizes only and for no other purpose. All expenditures shall be made in accordance with rules and regulations established by the office of administration. Prize payments may also be made from the state lottery fund. Prize payouts made pursuant to this section shall be subject to the provisions of section 143.781, RSMo; and prize payouts made pursuant to this section shall be subject to set off for delinquent child support payments as assessed by a court of competent jurisdiction or pursuant to section 454.410, RSMo. Prize payouts made under this section shall be subject to set off for unpaid health care services provided by hospitals and health care providers under the procedure established in section 143.790, RSMo.

4. Funds of the state lottery commission not currently needed for prize money, administration costs, commissions and promotion costs shall be invested by the state treasurer in interest-bearing investments in accordance with the investment powers of the state treasurer contained in chapter 30, RSMo. All interest earned by funds in the state lottery fund shall accrue to the credit of that fund.

5. No state or local sales tax shall be imposed upon the sale of lottery tickets or shares of the state lottery or on any prize awarded by the state lottery. No state income tax or local earnings tax shall be imposed upon any lottery game prizes which accumulate to an amount of less than six hundred dollars during a prize winner's tax year. The state of Missouri shall withhold for state income tax purposes from a lottery game prize or periodic payment of six hundred dollars or more an amount equal to four percent of the prize.

6. The director of revenue is authorized to enter into agreements with the lottery commission, in conjunction with the various state agencies pursuant to sections 143.782 to 143.788, RSMo, in an effort to satisfy outstanding debts to the state from the lottery winning of any person entitled to receive lottery payments which are subject to federal withholding. The director of revenue is also authorized to enter into agreements with the lottery commission **[**in conjunction with the department of health and senior services pursuant to section 143.790, RSMo,**]** in an effort to satisfy outstanding debts owed to hospitals and health care providers for unpaid health care services of any person entitled to receive lottery payments which are subject to federal withholding.

7. In addition to the restrictions provided in section 313.260, no person, firm, or corporation whose primary source of income is derived from the sale or rental of sexually oriented publications or sexually oriented materials or property shall be licensed as a lottery game retailer and any lottery game retailer license held by any such person, firm, or corporation shall be revoked.

354.536. 1. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such coverage shall continue while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the enrollee for support and maintenance. Proof of such incapacity and dependency must be furnished to the health maintenance organization by the enrollee **[**at least**] within** thirty-one days after the child's attainment of the limiting age. The health maintenance organization may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two-year period, the health maintenance organization may require subsequent proof not more than once each year.

2. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such plan, so long as it remains in force, until the dependent child attains the limiting age, shall remain in force at the option of the enrollee. The enrollee's election for continued coverage under this section shall be furnished to the health maintenance organization within thirty-one days after the child's attainment of the limiting age. As used in this subsection, a dependent child is a person who is:

(1) Unmarried and no more than twenty-five years of age; and

(2) A resident of this state; and

(3) Not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.

374.184. 1. The director of the department of insurance**, financial institutions and professional registration** shall prescribe by rule**[**,**] :**

(1) After due consultation with providers of health care or treatment and their respective licensing boards, **[**accident and sickness insurers, health services corporations and health maintenance organizations,**]** and after a public hearing, uniform claim forms for reporting by health care providers. Such prescribed forms shall include but need not be limited to information regarding the medical diagnosis, treatment and prognosis of the patient, together with the details of charges incident to the providing of such care, treatment or services, sufficient for the purpose of meeting the proof requirements of an accident and sickness insurance or hospital, medical or dental services contract. Such prescribed forms shall be based upon the UB-82 form, with

respect to hospital claims, and the HCFA 1500 form, with respect to physician claims, as such forms are modified or amended from time to time by the National Uniform Billing Committee or the federal Health Care Financing Administration**; and**

(2) After due consultation with accident and sickness insurers, health services corporations, health maintenance organizations, and insurance producers, and after a public hearing, uniform application forms.

2. The adoption of any uniform claim forms **or uniform application forms** by the director pursuant to this section shall not preclude an insurer, health services corporation, or health maintenance organization from requesting any necessary additional information in connection with a claims investigation from the claimant, provider of health care or treatment, or certifier of coverage**, or in connection with an application for insurance from the applicant**. The provisions of this section shall not be deemed or construed to apply to electronic claims submission. Insurers and providers may by contract provide for modifications to the uniform billing document where both insurers and providers feel that such modifications streamline claims processing procedures relating to the claims of the insurer involved in such contract modification. However, a refusal by the provider to agree to modification of the uniform billing format shall not be used by the insurer as grounds for refusing to enter into a contract with the provider for reimbursement or payment for health services rendered to an insured of the insurer.

3. Rules adopted or promulgated pursuant to this act shall be subject to notice and hearing as provided in chapter 536, RSMo. The regulations so adopted shall specify an effective date, which shall not be less than one hundred eighty days after the date of adoption, after which no accident and sickness insurer, health services corporation or health maintenance organization shall require providers of health care or treatment to complete forms differing from those prescribed by the director pursuant to this section, **[**and**]** after which no health care provider shall submit claims except upon such prescribed forms; provided that the provisions of this section shall not preclude the use by any insurer, health services corporation or health maintenance organization of the UB-82 form or the HCFA 1500 form**, and after which no insurer shall require applicants for insurance coverage to complete forms differing from those prescribed by the director under this section. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months or less duration, an individual policy of accident and sickness insurance, or any other policy determined by the director**.

376.426. No policy of group health insurance shall be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the director of insurance are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder; except that: provisions in subdivisions (5), (7), (12), (15), and (16) of this section shall not apply to policies insuring debtors; standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy:

(1) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue, and that no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by the person making such statement; except that, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy;

(3) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage;

(5) A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was **recommended or** received by the person during the **[**twelve**]** **six** months prior to the **[**effective**] enrollment** date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of:

(a) The end of a continuous period of twelve months commencing on or after the **[**effective**] enrollment** date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; or

(b) The end of the **[**two-year**] eighteen-month** period commencing on the **[**effective**]** **enrollment** date of the person's coverage **in the case of a late enrollee**;

(6) If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of the covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(7) A provision that the insurer shall issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage;

(8) A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;

(9) A provision that the insurer shall furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made;

(10) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of

such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required;

(11) A provision that all benefits payable under the policy other than benefits for loss of time shall be payable not more than thirty days after receipt of proof and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof;

(12) A provision that benefits for accidental loss of life of a person insured shall be payable to the beneficiary designated by the person insured or, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;

(13) A provision that the insurer shall have the right and opportunity, at the insurer's own expense, to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of the claim under the policy and also the right and opportunity, at the insurer's own expense, to make an autopsy in case of death where it is not prohibited by law;

(14) A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy;

(15) A provision specifying the conditions under which the policy may be terminated. Such provision shall state that except for nonpayment of the required premium or the failure to meet continued underwriting standards, the insurer may not terminate the policy prior to the first

anniversary date of the effective date of the policy as specified therein, and a notice of any intention to terminate the policy by the insurer must be given to the policyholder at least thirty-one days prior to the effective date of the termination. Any termination by the insurer shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received;

(16) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, shall be deemed to provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the certificate holder for support and maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the certificate holder **[**at least**] within** thirty-one days after the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such two-year period, the insurer may require subsequent proof not more than once each year. This subdivision shall apply only to policies delivered or issued for delivery in this state on or after one hundred twenty days after September 28, 1985;

(17) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, until the dependent child attains the limiting age, shall remain in force at the option of the certificate holder. Eligibility for continued coverage shall be established where the dependent child is:

(a) Unmarried and no more than **[**that**]** twenty-five years of age; and

(b) A resident of this state; and

(c) Not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.;

(18) In the case of a policy insuring debtors, a provision that the insurer shall furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness.

376.450. 1. Sections 376.450 to 376.454 shall be known and may be cited as the "Missouri Health Insurance Portability and Accountability Act". Notwithstanding any other provision of law to the contrary, health insurance coverage offered in connection with the small group market, the large group market and the individual market shall comply with the provisions

of sections 376.450 to 376.453 and, in the case of the small group market, the provisions of sections 379.930 to 379.952, RSMo. As used in sections 376.450 to 376.453, the following terms mean:

(1) "Affiliation period", a period which, under the terms of the coverage offered by a health maintenance organization, must expire before the coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period;

(2) "Beneficiary", the same meaning given such term under Section 3(8) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191;

(3) "Bona fide association", an association which:

(a) Has been actively in existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(d) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member); and

(e) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(f) Meets all other requirements for an association set forth in subdivision (5) of subsection 1 of section 376.421 that are not inconsistent with this subdivision;

(4) "COBRA continuation provision":

(a) Section 4980B of the Internal Revenue Code (26 U.S.C. 4980B), as amended, other than subsection (f)(1) of such section as it relates to pediatric vaccines;

(b) Title I, Subtitle B, Part 6, excluding Section 609, of the Employee Retirement Income Security Act of 1974; or

(c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.;

(5) "Creditable coverage", with respect to an individual:

(a) Coverage of the individual under any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such act;

e. Chapter 55 of Title 10, United States Code;

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under Title 5, Chapter 89, of the United States Code;

i. A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Services Act, as amended by Public Law 104-191;

j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(3));

k. Title XXI of the Social Security Act (SCHIP);

(b) Creditable coverage does not include coverage consisting solely of excepted benefits;

(6) "Department", the Missouri department of insurance, financial institutions and professional registration;

(7) "Director", the director of the Missouri department of insurance, financial institutions and professional registration;

(8) "Enrollment date", with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment;

(9) "Excepted benefits":

(a) Coverage only for accident (including accidental death and dismemberment) insurance;

(b) Coverage only for disability income insurance;

(c) Coverage issued as a supplement to liability insurance;

(d) Liability insurance, including general liability insurance and automobile liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

(i) Other similar insurance coverage, as approved by the director, under which benefits for medical care are secondary or incidental to other insurance benefits;

(j) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

c. Other similar limited benefits as specified by the director;

(k) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

(l) If offered as a separate policy, certificate, or contract of insurance, any of the following:

a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

c. Similar supplemental coverage provided to coverage under a group health plan;

(10) "Group health insurance coverage", health insurance coverage offered in connection with a group health plan;

(11) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent that the plan provides medical care, as defined in this section, and including any item or service paid for as medical care to an employee or the employee's dependent, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise, but not including excepted benefits;

(12) "Health insurance coverage", or "health benefit plan" as defined in section 376.1350 and benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise under a policy, certificate, membership contract, or health services agreement offered by a health insurance issuer, but not including excepted benefits;

(13) "Health insurance issuer", "issuer", or "insurer", an insurance company, health services corporation, fraternal benefit society, health maintenance organization, multiple employer welfare arrangement specifically authorized to operate in the state of Missouri, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(14) "Individual health insurance coverage", health insurance coverage offered to individuals in the individual market, not including excepted benefits or short-term limited duration insurance;

(15) "Individual market", the market for health insurance coverage offered to individuals other than in connection with a group health plan;

(16) "Large employer", in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

(17) "Large group market", the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a large employer;

(18) "Late enrollee", a participant who enrolls in a group health plan other than during the first period in which the individual is eligible to enroll under the plan, or a special enrollment period under subsection 6 of this section;

(19) "Medical care", amounts paid for:

(a) The diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) Transportation primarily for and essential to medical care referred to in paragraph (a) of this subdivision; or

(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this subdivision;

(20) "Network plan", health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer;

(21) "Participant", the same meaning given such term under Section 3(7) of the Employer Retirement Income Security Act of 1974 and Public Law 104-191;

(22) "Plan sponsor", the same meaning given such term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974;

(23) "Preexisting condition exclusion", with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information;

(24) "Public Law 104-191", the federal Health Insurance Portability and Accountability Act of 1996;

(25) "Small group market", the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan maintained by a small employer as defined in section 379.930, RSMo;

(26) "Waiting period", **[**with respect to a group health plan and an individual who is a potential participant or beneficiary in a group health plan,**]** the period that must pass **[**with respect to the individual before the individual is**] before coverage for an employee or dependent who**

is otherwise eligible to **[**be covered for benefits**] enroll** under the terms of **[**the**] a** group health plan **can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on:**

(a) If the application results in coverage, the date coverage begins;

(b) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

2. A health insurance issuer offering group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) Such exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(2) Such exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date; and

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant as of the enrollment date.

3. For the purposes of applying subdivision (3) of subsection 2 of this section:

(1) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under group health insurance coverage, if, after such period and before the enrollment date, there was a sixty-three day period during all of which the individual was not covered under any creditable coverage;

(2) Any period of time that an individual is in a waiting period for coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining whether a sixty-three day break under subdivision (1) of this subsection has occurred;

(3) Except as provided in subdivision (4) of this subsection, a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits included in the coverage;

(4) (a) A health insurance issuer offering group health insurance coverage may elect to apply the provisions of subdivision (3) of subsection 2 of this section based on coverage within any category of benefits within each of several classes or categories of benefits specified in regulations implementing Public Law 104-191, rather than as provided under subdivision (3) of this subsection. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a health insurance issuer shall count a period of creditable

coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(b) In the case of an election with respect to health insurance coverage offered by a health insurance issuer in the small or large group market under this subdivision, the health insurance issuer shall prominently state in any disclosure statements concerning the coverage, and prominently state to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and include in such statements a description of the effect of this election;

(5) Periods of creditable coverage with respect to an individual may be established through presentation of certifications and other means as specified in Public Law 104-191 and regulations pursuant thereto.

4. A health insurance issuer offering group health insurance coverage shall not apply any preexisting condition exclusion in the following circumstances:

(1) Subject to subdivision (4) of this subsection, a health insurance issuer offering group health insurance coverage shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-one-day period beginning with the date of birth, is covered under creditable coverage;

(2) Subject to subdivision (4) of this subsection, a health insurance issuer offering group health insurance coverage shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

(3) A health insurance issuer offering group health insurance coverage shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition;

(4) Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

5. A health insurance issuer offering group health insurance coverage shall provide a certification of creditable coverage as required by Public Law 104-191 and regulations pursuant thereto.

6. A health insurance issuer offering group health insurance coverage shall provide for special enrollment periods in the following circumstances:

(1) A health insurance issuer offering group health insurance in connection with a group health plan shall permit an employee or a dependent of an employee who is eligible but not enrolled for coverage under the terms of the plan to enroll for coverage if:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time that coverage was previously offered to the employee or dependent;

(b) The employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time;

(c) The employee's or dependent's coverage described in paragraph (a) of this subdivision was:

a. Under a COBRA continuation provision and was exhausted; or

b. Not under a COBRA continuation provision and was terminated as a result of loss of eligibility for the coverage or because employer contributions toward the cost of coverage were terminated; and

(d) Under the terms of the group health plan, the employee requests the enrollment not later than thirty days after the date of exhaustion of coverage described in subparagraph a. of paragraph (c) of this subdivision or termination of coverage or employer contributions described in subparagraph b. of paragraph (c) of this subdivision;

(2) (a) A group health plan shall provide for a dependent special enrollment period described in paragraph (b) of this subdivision during which an employee who is eligible but not enrolled and a dependent may be enrolled under the group health plan and, in the case of the birth or adoption **or placement for adoption** of a child, the spouse of the employee may be enrolled as a dependent if the spouse is otherwise eligible for coverage.

(b) A dependent special enrollment period under this subdivision is a period of not less than thirty days that begins on the date of the marriage or adoption or placement for adoption, or the period provided for enrollment in section 376.406 in the case of a birth;

(3) The coverage becomes effective:

(a) In the case of marriage, not later than the first day of the first month beginning after the date on which the completed request for enrollment is received;

(b) In the case of a dependent's birth, as of the date of birth; or

(c) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

7. In the case of group health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

(1) No preexisting condition exclusion is imposed with respect to coverage through the organization;

(2) The period is applied uniformly without regard to any health status-related factors;

(3) Such period does not exceed two months, or three months in the case of a late enrollee;

(4) Such period begins on the enrollment date; and

(5) Such period runs concurrently with any waiting period.

376.453. 1. An employer that provides health insurance coverage for which any portion of the premium is payable by the **[**employer**] employee** shall not provide such coverage unless the employer has established a premium-only cafeteria plan as permitted under federal law, 26 U.S.C. Section 125 **or a health reimbursement arrangement as permitted under federal law, 26 U.S.C. Section 105**. The provisions of this subsection shall not apply to employers who offer health insurance through any self-insured or self-funded group health benefit plan of any type or description.

2. Nothing in this section shall prohibit or otherwise restrict an employer's ability to either provide a group health benefit plan or create a premium-only cafeteria plan with defined contributions and in which the employee purchases the policy.

376.685. 1. Notwithstanding any provision of the law to the contrary, health carriers may include wellness and health promotion programs, condition or disease management programs, health risk appraisal programs, and similar provisions in high deductible health plans or policies that comport with federal requirements, provided that such wellness and health promotion programs are approved by the department of insurance, financial institutions and professional registration.

2. Health carriers that include and operate wellness and health promotion programs, disease and condition management programs, health risk appraisal programs, and similar provisions in high deductible health plans or policies that comport with federal requirements shall not be considered to be engaging in unfair trade practices under section 375.936 with respect to references to the practices of illegal inducements, unfair discrimination, and rebating.

3. As used in this section, a "high deductible health plan" shall mean a policy or contract of health insurance or health benefit plan, as defined in section 376.1350, that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

376.776. 1. This section applies to the hospital and medical expense provisions of an accident or sickness insurance policy.

2. If a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy so long as it remains in force shall be deemed to provide that attainment of such limiting age does not operate to

terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the policyholder for support and maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the policyholder **[**at least**] within** thirty-one days after the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two-year period, the insurer may require subsequent proof not more than once each year.

3. If a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force until the dependent child attains the limiting age, shall remain in force at the option of the policyholder. The policyholder's election for continued coverage under this section shall be furnished by the policyholder to the insurer within thirty-one days after the child's attainment of the limiting age. As used in this subsection, a dependent child is a person who:

(1) Is a resident of this state;

(2) Is unmarried and no more than twenty-five years of age; and

(3) **Is** not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.

4. This section applies only to policies delivered or issued for delivery in this state more than one hundred twenty days after October 13, 1967.

376.960. As used in sections 376.960 to **[**376.989**] 376.991**, the following terms mean:

(1) "Benefit plan", the coverages to be offered by the pool to eligible persons pursuant to the provisions of section 376.986;

(2) "Board", the board of directors of the pool;

(3) "Church plan", a plan as defined in Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended;

(4) "Creditable coverage", with respect to an individual:

(a) Coverage of the individual provided under any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;

e. Chapter 55 of Title 10, United States Code;

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under Chapter 89 of Title 5, United States Code;

i. A public health plan as defined in federal regulations; or

j. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);

(b) Creditable coverage does not include coverage consisting solely of excepted benefits;

(5) "Department", the Missouri department of insurance, financial institutions and professional registration;

(6) "Dependent", a resident spouse or resident unmarried child under the age of nineteen years, a child who is a student under the age of twenty-five years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent;

(7) "Director", the director of the Missouri department of insurance, financial institutions and professional registration;

(8) "Excepted benefits":

(a) Coverage only for accident, including accidental death and dismemberment, insurance;

(b) Coverage only for disability income insurance;

(c) Coverage issued as a supplement to liability insurance;

(d) Liability insurance, including general liability insurance and automobile liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

(i) Other similar insurance coverage, as approved by the director, under which benefits for medical care are secondary or incidental to other insurance benefits;

(j) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

c. Other similar, limited benefits as specified by the director;

(k) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

(l) If offered as a separate policy, certificate or contract of insurance, any of the following:

a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

c. Similar supplemental coverage provided to coverage under a group health plan;

(9) "Federally defined eligible individual", an individual:

(a) For whom, as of the date on which the individual seeks coverage through the pool, the aggregate of the periods of creditable coverage as defined in this section is eighteen or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act or any successor program, and who does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated because of nonpayment of premiums or fraud;

(d) Who, if offered the option of continuation coverage under COBRA continuation provision or under a similar state program, both elected and exhausted the continuation coverage;

(10) "Governmental plan", a plan as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

(11) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise, but not including excepted benefits;

(12) "Health insurance", any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provisions of health care benefits. The term "health insurance" does not include accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(13) "Health maintenance organization", any person which undertakes to provide or arrange for basic and supplemental health care services to enrollees on a prepaid basis, or which meets the requirements of section 1301 of the United States Public Health Service Act;

(14) "Hospital", a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical condition; or a place devoted primarily to provide medical or nursing care for three or more nonrelated individuals for not less than twenty-four hours in any week. The term "hospital" does not include convalescent, nursing, shelter or boarding homes, as defined in chapter 198, RSMo;

(15) "Insurance arrangement", any plan, program, contract or other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administration, health care services or benefits other than through an insurer;

(16) "Insured", any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement, as defined in this section;

(17) "Insurer", any insurance company authorized to transact health insurance business in this state, any nonprofit health care service plan act, or any health maintenance organization;

(18) "Medical care", amounts paid for:

(a) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(b) Transportation primarily for and essential to medical care referred to in paragraph (a) of this subdivision; and

(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this subdivision;

(19) "Medicare", coverage under both part A and part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended;

(20) "Member", all insurers and insurance arrangements participating in the pool;

(21) "Physician", physicians and surgeons licensed under chapter 334, RSMo, or by state board of healing arts in the state of Missouri;

(22) "Plan of operation", the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to the provisions of sections 376.961, 376.962 and 376.964;

(23) "Pool", the state health insurance pool created in sections 376.961, 376.962 and 376.964;

(24) "Resident", an individual who has been legally domiciled in this state for a period of at least thirty days, except that for a federally defined eligible individual, there shall not be a thirty-day requirement;

(25) "Significant break in coverage", a period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage**. As used in this subdivision, "waiting period" and "affiliation period" shall have the same meaning as such terms are defined in section 376.450**;

(26) "Trade act eligible individual", an individual who is eligible for the federal health coverage tax credit under the Trade Act of 2002, Public Law 107-210.

376.962. 1. The board of directors on behalf of the pool shall submit to the director a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. After notice and hearing, the director shall approve the plan of operation, provided it is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and it provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the director consistent with the date on which the coverage under sections 376.960 to 376.989 becomes available. If the pool fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the pool and approved by the director.

2. In its plan, the board of directors of the pool shall:

(1) Establish procedures for the handling and accounting of assets and moneys of the pool;

(2) Select an administering insurer in accordance with section 376.968;

(3) Establish procedures for filling vacancies on the board of directors;

(4) **[**Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board pursuant to the provisions of section 376.973. Assessment shall occur at the end of each calendar year and shall be due and payable within thirty days of receipt of the assessment notice;

(5)**]** Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

376.966. 1. No employee shall involuntarily lose his or her group coverage by decision of his or her employer on the grounds that such employee may subsequently enroll in the pool. The department shall have authority to promulgate rules and regulations to enforce this subsection.

2. The following individual persons shall be eligible for coverage under the pool if they are and continue to be residents of this state:

(1) An individual person who provides evidence of the following:

(a) A notice of rejection or refusal to issue substantially similar health insurance for health reasons by at least two insurers; or

(b) A refusal by an insurer to issue health insurance except at a rate exceeding the plan rate for substantially similar health insurance;

(2) A federally defined eligible individual who has not experienced a significant break in coverage;

(3) A trade act eligible individual;

(4) Each resident dependent of a person who is eligible for plan coverage;

(5) Any person, regardless of age, that can be claimed as a dependent of a trade act eligible individual on such trade act eligible individual's tax filing;

(6) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium or fraud, and who is not otherwise ineligible under subdivision (4) of subsection 3 of this section. If application for pool coverage is made not later than sixty-three days after the involuntary termination, the effective date of the coverage shall be the date of termination of the previous coverage;

(7) Any person whose premiums for health insurance coverage have increased above the rate established by the board under paragraph (a) of subdivision (1) of subsection 3 of this section;

(8) Any person currently insured who would have qualified as a federally defined eligible individual or a trade act eligible individual between the effective date of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the effective date of this act**;**

(9) Any person who has exhausted his or her maximum in benefits from a health insurer.

3. The following individual persons shall not be eligible for coverage under the pool:

(1) Persons who have, on the date of issue of coverage by the pool, or obtain coverage under health insurance or an insurance arrangement substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it, except that:

(a) This exclusion shall not apply to a person who has such coverage but whose premiums have increased to **[**one hundred fifty percent to**]** **beyond the eligibility limit set by the board. The board shall not set the eligibility limit in excess of** two hundred percent of rates established by the board as applicable for individual standard risks**[**. After December 31, 2009, this exclusion shall not apply to a person who has such coverage but whose premiums have increased to three hundred percent or more of rates established by the board as applicable for individual standard risks**]**;

(b) A person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a pool policy; **[**and**]**

(c) A person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the pool policy; **and**

(d) Such exclusion shall not apply to a federally defined eligible individual;

(2) Any person who is at the time of pool application receiving health care benefits under section 208.151, RSMo;

(3) Any person having terminated coverage in the pool unless twelve months have elapsed since such termination, unless such person is a federally defined eligible individual;

(4) Any person on whose behalf the pool has paid out **[**one**]** **two** million dollars in benefits;

(5) Inmates or residents of public institutions, unless such person is a federally defined eligible individual, and persons eligible for public programs;

(6) Any person whose medical condition which precludes other insurance coverage is directly due to alcohol or drug abuse or self-inflicted injury, unless such person is a federally defined eligible individual or a trade act eligible individual;

(7) Any person who is eligible for Medicare coverage.

4. Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of such person's policy period.

5. If an insurer issues one or more of the following or takes any other action based wholly or partially on medical underwriting considerations which is likely to render any person eligible for pool coverage, the insurer shall notify all persons affected of the existence of the pool, as well as the eligibility requirements and methods of applying for pool coverage:

(1) A notice of rejection or cancellation of coverage;

(2) A notice of reduction or limitation of coverage, including restrictive riders, if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.

6. When an insurer determines an insured has exhausted eighty-five percent of his or her total lifetime benefits, the insurer shall notify any affected person of the existence of the pool, of the person's eligibility for the pool when all lifetime benefits have been exhausted, and of methods of applying for pool coverage. When any affected person has exhausted one hundred percent of his or her total lifetime benefits, the insurer shall notify the affected person of his or her eligibility for pool coverage and of the methods of applying for such coverage. The insurer shall provide a copy of such notice to the pool with the name and address of such affected person.

376.981. The pool shall offer individual stop-loss coverage for any insurer licensed providing individual health insurance policies in this state. Such stop-loss coverage, if available, shall be provided by the pool or an insurer licensed by the state to write accident and health insurance on a direct basis. The stop-loss coverage shall cover claim liability for an insured person in the individual market who becomes uninsurable and any uninsurable dependent of an insured person, if coverage for an uninsurable dependent is requested. The stop-loss insurer shall bear the risk of coverage for such uninsurable persons.

376.983. 1. The pool shall establish a two-year pilot program that offers small employer group stop-loss coverage for health insurers providing health insurance coverage in the small employer group market in the metropolitan statistical area of a home rule city with more than four hundred thousand inhabitants and located in more than one county and in the metropolitan statistical area of a home rule city with more than one hundred fifty-one thousand five hundred but fewer than one hundred fifty-one thousand six hundred inhabitants. The board shall promulgate rules for implementation of the pilot program established under this section.

2. (1) For purposes of this section, small employer shall have the same meaning as such term is defined in section 379.930, RSMo.

(2) The stop-loss coverage offered under this section may be provided by the pool, an insurer, or an approved reinsurer.

(3) The pool board shall have the authority to set actuarially sound rates to be charged for such stop-loss coverage taking into consideration anticipated tax premium revenue and other available sources of income.

3. To be eligible to purchase small employer group stop-loss coverage under the pool:

(1) The insurer shall not be permitted to purchase small employer group stop-loss coverage from the pool in the aggregate, but shall be required to purchase a separate stop-loss policy for each small employer group policy for which stop-loss coverage is being sought through the pool;

(2) The insurer shall provide the pool with sufficient information, to be determined by the board, establishing a need for the purchase of such stop-loss coverage for a small employer group policy of the insurer. The insurer shall establish to the satisfaction of the pool board at a minimum that the purchase of stop-loss coverage for a small employer group policy will stabilize the standard risk rate for such small employer group policy;

(3) The stop-loss coverage provided through the pool shall cover claim liability for each individual risk within the small employer group health plan that exceeds the annual individual claim liability threshold under subdivision (4) of this subsection;

(4) Stop-loss coverage criteria shall be established by the pool board with the following minimums:

(a) The stop-loss coverage purchased from the pool shall provide coverage in accordance with paragraphs (c) and (d) of this subdivision for claim risks for individuals insured through a small employer group health plan issued in Missouri that exceeds a per policy year individual claim payments threshold to be set by the board;

(b) The stop-loss coverage purchased from the pool shall provide coverage in accordance with paragraphs (c) and (d) of this subdivision for claim risks for individuals in a small employer group health plan issued in Missouri if individual claim payments for the year exceed an individual claim payments threshold to be set by the board;

(c) An insurer purchasing stop-loss coverage from the pool shall retain a portion of the risk associated with the individual insured through the small employer group (risk corridor) and shall be liable for a portion of such individual's claims. The insurer's retained risk shall not be less than thirty percent of claims within the risk corridor of a policy year claims associated with such individual risk being reinsured. The risk corridor shall be established by the board;

(d) An insurer purchasing stop-loss coverage from the pool shall retain a portion of the risk for the small employer group in the aggregate and shall be liable for that portion of all claims associated with the small employer group. The retained risk shall not be less than an aggregate of one hundred twenty percent of expected claims for the entire small employer group; and

(e) The threshold and risk corridor established in paragraphs (a) to (c) of this subdivision shall be periodically reviewed by the board and may be adjusted for appropriate factors as determined by the board.

4. By January 1, 2011, the board shall submit a report to the general assembly regarding the pilot project established under this section and any recommendations for expanding the program statewide.

5. The board, in conjunction with the department of insurance, financial institutions and professional registration, may promulgate rules for the administration and implementation 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, 2008, shall be invalid and void.

376.985. 1. Beginning July 1, 2008, the pool shall offer at least two plans for uninsurable individuals eligible under the insure Missouri program established under sections 1 to 8 of this act that meets the criteria of the federal Centers for Medicare and Medicaid for such program. No person related within the second degree of consanguinity or affinity of a statewide officeholder who is working as a lobbyist, consultant, or principal shall be awarded a contract for services under sections 1 to 8 of this act. No entity employing such person or clients of such person or entity shall be awarded a contract for services under sections 1 to 8 of this act. For purposes of this section and section 376.986, an uninsurable individual shall be defined by the eligibility criteria in subsection 2 of section 376.966.

2. Any individual receiving health insurance coverage under the state health insurance pool whose income is less than two hundred twenty-five percent of the federal poverty level may apply for participation in the insure Missouri program. The pool shall provide information to pool participants on how to apply for participation in the insure Missouri program.

3. Subject to available funds, the board may establish a premium subsidy program for low-income persons who are eligible for participation in the high-risk pool in accordance with the premiums established under section 376.986. The program may include incentives designed to encourage and promote healthy lifestyle choices which are appropriate and attainable for such participants, taking into consideration any limitations on lifestyle choices which exist based on the medical conditions and needs of the population served under the high-risk pool.

376.986. 1. The pool shall offer major medical expense coverage to every person eligible for coverage under section 376.966 **and may offer other health plans that the board determines to be in the best interest of the individuals covered under the pool**. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations, shall be established by the board with the advice and recommendations of the pool members, and such plan of pool coverage shall be submitted to the director for approval. The pool shall also offer coverage for drugs and supplies requiring a medical prescription and coverage for patient education services, to be provided at the direction of a physician, encompassing the provision of information, therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of the covered condition, illness or defect.

2. In establishing the pool coverage the board shall take into consideration the levels of health insurance provided in this state and medical economic factors as may be deemed appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of insurers in this state.

3. The pool shall establish premium rates for pool coverage as provided in **[**subsection 4**] subsections 4 and 5** of this section. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the director for approval prior to use.

4. The pool, with the assistance of the director, shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. **[**Initial rates for pool coverage shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks.**]** Subject to the limits provided in this subsection, **[**subsequent**]** rates shall be established **in accordance with the premium rate schedule in subsection 5 of this section** to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed the following:

(1) For federally defined eligible individuals and trade act eligible individuals, rates shall be equal to the percent of rates applicable to individual standard risks actuarially determined to be sufficient to recover the sum of the cost of benefits paid under the pool for federally defined and trade act eligible individuals plus the proportion of the pool's administrative expense applicable to federally defined and trade act eligible individuals enrolled for pool coverage, provided that such rates shall not exceed **[**one hundred fifty**] the limits established in**

subsection 5 of this section, not to exceed two hundred percent of rates applicable to individual standard risks; and

(2) For all other individuals covered under the pool, **[**one hundred fifty percent of rates**]** **the rate limits established under subsection 5 of this section** applicable to individual standard risks.

5. **Premium rates for pool coverage shall be established in accordance with the following schedule:**

(1) For individuals with incomes of less than three hundred percent of the federal poverty level, a premium rate equal to the standard risk rates;

(2) For individuals with incomes of three hundred percent of the federal poverty level or more, a sliding scale premium rate based on income which is between one hundred and one hundred twenty-five percent of the standard risk rates established by rule.

6. For uninsurable individuals eligible for the insure Missouri program established under sections 1 to 8 of this act, the pool shall offer the coverage required under subsection 1 of section 376.985 to such individuals at the standard risk rates of the pool subject to the following:

(1) The department of social services shall pay all or a portion of the premium for such coverage for an individual in the same manner authorized under the insure Missouri program;

(2) If the premium exceeds the amount paid by the department under this subsection, the individual covered shall be responsible for payment of any premium for such coverage not paid by the department;

(3) For insure Missouri program participants who are eligible for federal participation moneys, the losses covered under the pool for such individuals may, in accordance with the requirements of the federal waiver for such program, exceed the standard risk rates of the pool; and

(4) Premiums shall be certified as actuarially sound in accordance with the requirements established by the federal Centers for Medicare and Medicaid Services.

7. Commission payments for the sale of Missouri health insurance pool policies shall be set by the board. The board shall provide that agents and brokers selling insure Missouri qualified plans comply with the federal Centers for Medicare and Medicaid Services requirements concerning marketing and plan enrollment for insure Missouri program participants eligible for federal participation.

8. Pool coverage established pursuant to this section shall provide an appropriate high and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors

may be adjusted annually in accordance with the medical component of the consumer price index.

[6.**] 9.** Pool coverage shall exclude charges or expenses incurred during the first **[**twelve**]** **six** months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such condition during the six-month period immediately preceding the effective date of coverage. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, if application for pool coverage is made not later than sixty-three days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

[7.**] 10.** No preexisting condition exclusion shall be applied to the following:

(1) A federally defined eligible individual who has not experienced a significant gap in coverage; or

(2) A trade act eligible individual who maintained creditable health insurance coverage for an aggregate period of three months prior to loss of employment and who has not experienced a significant gap in coverage since that time.

[8.**] 11.** Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid. The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

[9.**] 12.** Medical expenses shall include expenses for comparable benefits for those who rely solely on spiritual means through prayer for healing.

376.987. 1. The board shall offer to all eligible persons for pool coverage under section 376.966 the option of receiving health insurance coverage through a high-deductible health plan and the establishment of a health savings account**, or other similar account**. In order for a qualified individual to obtain a high-deductible health plan through the pool, such individual shall present evidence, in a manner prescribed by regulation, to the board that he or she has established a health savings account in compliance with 26 U.S.C. Section 223, and any amendments and regulations promulgated thereto.

2. As used in this section, the term "health savings account" shall have the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended. The term "high-deductible health plan" shall mean a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

3. **The utilization of high deductible plans and the establishment of health savings accounts or other similar accounts shall be reviewed and reassessed annually by the appropriate legislative committees of the general assembly.**

4. The board is authorized to promulgate rules and regulations for the administration and implementation 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, 2007, shall be invalid and void.

376.991. 1. Notwithstanding any other provision of law to the contrary, beginning January 1, 2009, any premium tax imposed and collected in connection with the conduct of business in this state by a health carrier for premiums for any health benefit plan insurance shall be distributed to the health insurance pool established under sections 376.960 to 376.991, as follows:

(1) For fiscal years 2009 and 2010, fifty percent of all such premium taxes collected;

(2) For fiscal year 2011 and every fiscal year thereafter, one hundred percent of all such premium taxes collected.

2. For purposes of this section, health benefit plan and health carrier shall have the same meaning as such terms are defined in section 376.1350.

376.1600. 1. The director of the department of insurance, financial institutions and professional registration is authorized to allow employees to use funds from one or more employer health reimbursement arrangement only plans to help pay for coverage in the individual health insurance market. This will encourage employer financial support of health insurance or health-related expenses recognized under the rules of the federal Internal Revenue Service. Health reimbursement arrangement only plans that are not sold in connection with or packaged with individual health insurance policies shall not be considered insurance under this chapter.

2. As used in this section, the term "health reimbursement arrangement" shall mean an employee benefit plan provided by an employer which:

(1) Establishes an account or trust which is funded solely by the employer and not through a salary reduction or otherwise under a cafeteria plan established pursuant to Section 125 of the Internal Revenue Code of 1986;

(2) Reimburses the employee for qualified medical care expenses, as defined by 26 U.S.C. Section 213(d), incurred by the employee and the employee's spouse and dependents;

(3) Provides reimbursements up to a maximum stated dollar amount for a defined coverage period; and

(4) Carries forward any unused portion of the maximum dollar amount at the end of the coverage period to increase the maximum reimbursement amount in subsequent coverage periods.

376.1618. The director shall study and recommend to the general assembly changes to remove any unnecessary application and marketing barriers that limit the entry of new health insurance products into the Missouri market. The director shall examine state statutory and regulatory requirements along with market conditions which create barriers for the entry of new health insurance products and health insurance companies. The director shall also examine proposals adopted in other states that streamline the regulatory environment to make it easier for health insurance companies to market new and existing products. The director shall submit a report of his or her findings and recommendations to each member of the general assembly no later than January 1, 2009.

379.930. 1. Sections 379.930 to 379.952 shall be known and may be cited as the "Small Employer Health Insurance Availability Act".

2. For the purposes of sections 379.930 to 379.952, the following terms shall mean:

(1) "Actuarial certification", a written statement by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 379.936, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

(2) "Affiliate" or "affiliated", any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person;

(3) "Base premium rate", for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of

business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

(4) "Board" **[**means**] ,** the board of directors of the program established pursuant to sections 379.942 and 379.943;

(5) "Bona fide association", an association which:

(a) Has been actively in existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(d) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(e) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(f) Meets all other requirements for an association set forth in subdivision (5) of subsection 1 of section 376.421, RSMo, that are not inconsistent with this subdivision;

(6) "Carrier" or "health insurance issuer", any entity that provides health insurance or health benefits in this state. For the purposes of sections 379.930 to 379.952, carrier includes an insurance company, health services corporation, fraternal benefit society, health maintenance organization, multiple employer welfare arrangement specifically authorized to operate in the state of Missouri, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(7) "Case characteristics", demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage since issue shall not be case characteristics for the purposes of sections 379.930 to 379.952;

(8) "Church plan", the meaning given such term in Section 3(33) of the Employee Retirement Income Security Act of 1974;

(9) "Class of business", all or a separate grouping of small employers established pursuant to section 379.934;

(10) "Committee", the health benefit plan committee created pursuant to section 379.944;

(11) "Control" shall be defined in manner consistent with chapter 382, RSMo;

(12) "Creditable coverage", with respect to an individual:

(a) Coverage of the individual under any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such act;

e. Chapter 55 of Title 10, United States Code;

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under Chapter 89 of Title 5, United States Code;

i. A public health plan, as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Services Act, as amended by Public Law 104-191; and

j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e));

(b) Creditable coverage shall not include coverage consisting solely of excepted benefits;

(13) "Dependent", a spouse **[**or**] ;** an unmarried child **[**under the age of nineteen years; an unmarried child who is a full-time student under the age of twenty-three years and who is financially dependent upon the parent**] who is a resident of this state, is under the age of twenty-five years, and is not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the federal Social Security Act, 42 U.S.C. Section 1395, et seq.**; or an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

(14) "Director", the director of the department of insurance, financial institutions and professional registration of this state;

(15) "Eligible employee", an employee who works on a full-time basis and has a normal work week of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis. For purposes of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only one eligible employee when they are employed by the same small employer;

(16) "Established geographic service area", a geographical area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage;

(17) "Excepted benefits":

(a) Coverage only for accident (including accidental death and dismemberment) insurance;

(b) Coverage only for disability income insurance;

(c) Coverage issued as a supplement to liability insurance;

(d) Liability insurance, including general liability insurance and automobile liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

(i) Other similar insurance coverage, as approved by the director, under which benefits for medical care are secondary or incidental to other insurance benefits;

(j) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

c. Other similar, limited benefits as specified by the director.

(k) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance.

(l) If offered as a separate policy, certificate or contract of insurance, any of the following:

a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

c. Similar supplemental coverage provided to coverage under a group health plan;

(18) "Governmental plan", the meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 or any federal government plan;

(19) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent that the plan provides medical care, as defined in this section, and including any item or service paid for as medical care to an employee or the employee's dependent, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise, but not including excepted benefits;

(20) "Health benefit plan" or "health insurance coverage", benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through

insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health services agreement offered by a health insurance issuer, but not including excepted benefits or a policy that is individually underwritten;

(21) "Health status-related factor", any of the following:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including a condition arising out of an act of domestic violence;

(h) Disability;

(22) "Index rate", for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic mean of the applicable base premium rate and the corresponding highest premium rate;

(23) "Late enrollee", an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, provided that such initial enrollment period is a period of at least thirty days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

a. The individual was covered under creditable coverage at the time of the initial enrollment;

b. The individual lost coverage under creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, dissolution or legal separation;

c. The individual requests enrollment within thirty days after termination of the creditable coverage;

(b) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order;

(24) "Medical care", an amount paid for:

(a) The diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;

(b) Transportation primarily for and essential to medical care referred to in paragraph (a) of this subdivision; or

(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this subdivision;

(25) "Network plan", health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer;

(26) "New business premium rate", for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

(27) "Plan of operation", the plan of operation of the program established pursuant to sections 379.942 and 379.943;

(28) "Plan sponsor", the meaning given such term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974;

(29) "Premium", all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan;

(30) "Producer", the meaning given such term in section 375.012, RSMo, and includes an insurance agent or broker;

(31) "Program", the Missouri small employer health reinsurance program created pursuant to sections 379.942 and 379.943;

(32) "Rating period", the calendar period for which premium rates established by a small employer carrier are assumed to be in effect;

(33) "Restricted network provision", any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to section 354.400, RSMo, et seq. to provide health care services to covered individuals;

(34) "Small employer", in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or political subdivision that is actively engaged in business that employed an average of at least two but no more than fifty eligible employees on business days during the preceding calendar year and that employs at least two employees on the first day of the plan year. All persons treated as a single

employer under subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of sections 379.930 to 379.952 that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in sections 379.930 to 379.952 to an employer shall include a reference to any predecessor of such employer;

(35) "Small employer carrier", a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

3. Other terms used in sections 379.930 to 379.952 not set forth in subsection 2 of this section shall have the same meaning as defined in section 376.450, RSMo.

379.940. 1. (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state, except for plans developed for health benefit trust funds.

(2) (a) A small employer carrier shall issue a health benefit plan to any eligible small employer that applies for either such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with sections 379.930 to 379.952.

(b) In the case of a small employer carrier that establishes more than one class of business pursuant to section 379.934, the small employer carrier shall maintain and issue to eligible small employers **[**all health benefit plans**]** in each class of business so established **all health benefit plans it actively markets to small employers in this state**. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

a. The criteria are not intended to discourage or prevent acceptance of small employers applying for a health benefit plan;

b. The criteria are not related to the health status or claim experience of the small employer;

c. The criteria are applied consistently to all small employers applying for coverage in the class of business; and

d. The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business. The provisions of this paragraph shall not apply to a class of business into which the small employer carrier is no longer enrolling new small employers.

2. Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall comply with the provisions of sections 376.450 and 376.451, RSMo.

(2) (a) Except as provided in paragraph (d) of this subdivision, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(b) A small employer carrier shall not require a minimum participation level greater than:

a. One hundred percent of eligible employees working for groups of three or less employees; and

b. Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(d) A small employer carrier shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(3) (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.

(b) A small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(c) An eligible employee may choose to retain their individually underwritten health benefit plan at the time such eligible employee is entitled to enroll in a small employer health benefit plan. If the eligible employee retains their individually underwritten health benefit plan,

a small employer may provide a defined contribution through the establishment of a cafeteria 125 plan **or health reimbursement arrangement** under section **[**379.953**] 376.453, RSMo**. Small employers shall establish an equal amount of defined contribution for all plans. If an eligible employee retains their individually underwritten health benefit plan under this subdivision, the provisions of sections 379.930 to 379.952 shall not apply to the individually underwritten health benefit plan.

3. (1) Subject to subdivision (3) of this subsection, a small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection 1 of this section in the case of the following:

(a) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;

(b) To an employee, when the employee does not live, work or reside within the carrier's established geographic service area; or

(c) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(2) A small employer carrier that cannot offer coverage pursuant to paragraph (c) of subdivision (1) of this subsection may not offer coverage in the applicable area to new cases of employer groups with more than fifty eligible employees or to any small employer groups until the later of one hundred eighty days following each such refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to small employer groups.

(3) A small employer carrier shall apply the provisions of this subsection uniformly to all small employers without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

4. A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection 1 of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of subsection 1 of this section would place the small employer carrier in a financially impaired condition, and the small employer is applying this subsection uniformly to all small employers in the small group market in this state consistent with applicable state law and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

379.952. 1. Each small employer carrier shall actively market all health benefit plans sold by the carrier in the small group market to eligible employers in the state, except for plans developed for health benefit trust funds.

2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier or agent or broker shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) The provisions of subdivision (1) of this subsection shall not apply with respect to information provided by a small employer carrier or agent or broker to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

3. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) Subdivision (1) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

4. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent or broker, if any, for the sale of a **[**basic or standard**] small employer** health benefit plan.

5. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with an agent or broker for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent or broker with the small employer carrier.

6. No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment; except that, a carrier may offer a policy to a small employer that charges a reduced premium rate or deductible for employees who do not smoke or use tobacco products, and such carrier shall not be considered in violation of sections

379.930 to 379.952 or any unfair trade practice, as defined in section **[**379.936**] 375.936, RSMo**, even if only some small employers elect to purchase such a policy and other small employers do not.

7. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial with specificity.

8. The director may promulgate rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

9. (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under sections 375.930 to 375.949, RSMo.

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Section 1. 1. As used in sections 1 to 8 of this act, the following terms shall mean:

(1) "Department", the department of social services;

(2) "Health insurance pool" or "pool", the health insurance pool established under sections 376.960 to 376.991, RSMo;

(3) "Insure Missouri program" or "program", the insure Missouri initiative established in sections 1 to 8 of this act;

(4) "Prevention and wellness services", medically appropriate and age appropriate care that is provided to an individual to prevent and diagnose disease, and promote good health and a healthy lifestyle;

(5) "Qualified plan", any health benefit plan available in the private individual health insurance market or through the health insurance pool established under sections 376.960 to 376.991, RSMo, that is determined by the department of insurance, financial institutions and professional registration to meet the minimum benefit design contained in the federal waiver authorizing the insure Missouri program.

2. There is hereby established within the department of social services the "Insure Missouri Program" to provide health care coverage through the private insurance market to low-income working adults residing in this state. The department shall apply to the United States Department of Health and Human Services for approval of a Section 1115 demonstration waiver to develop and implement the program. Such submitted waiver shall include but not be limited to:

(1) A provision that allows for transitional participation in the program as set forth in subsection 3 of section 6 of this act; and

(2) For uninsurable individuals receiving coverage through the state's health insurance pool, a provision that allows for:

(a) Federal participation moneys to be used to provide such uninsurable individuals with pool coverage under the program; and

(b) Actuarially sound premium rates for coverage for such individuals that exceed the standard risk rates of the health insurance pool based on the aggregate losses for all such individuals eligible for federal participation moneys.

3. Prior to the submission of an application for a federal waiver under subsection 2 of this section, the department shall submit the proposed application for such waiver to the joint committee on MO HealthNet for the committee's review, recommendations, and approval.

4. The program is not an entitlement program. The maximum enrollment of individuals who may participate in the program is dependent on funding appropriated for the program by the general assembly. Eligibility for the program may be phased in incrementally on the basis of actions taken by the general assembly in the appropriations process.

5. Notwithstanding any other provision of sections 1 to 8 of this act to the contrary, for uninsurable individuals receiving coverage through the state's health insurance pool, such individuals shall be eligible for participation under the program as long as they are otherwise eligible for participation in the program and their incomes do not exceed two hundred twenty-five percent of the federal poverty level.

6. The department shall establish standards for consumer protection, including the following:

(1) Quality of care standards;

(2) A uniform process for participant grievances and appeals;

(3) Standardized reporting concerning provider performance, consumer experience, and cost.

7. The insure Missouri program shall pay one hundred percent of the premium costs for all participants in the program, except for any participant whose balance in his or her insure Missouri account at the end of the plan year exceeds the total annual required contribution amount under subdivision (2) of subsection 2 of section 5 of this act. Any amount in a participant's insure Missouri account at the end of the plan year that exceeds the participant's total annual required contribution amount shall go toward payment of the participant's premium costs under the program.

Section 2. 1. An individual shall be eligible for participation in the program if the individual meets the following requirements:

(1) The individual is at least nineteen years of age and less than sixty-five years of age;

(2) The individual is a United States citizen or qualified legal alien and a resident of Missouri;

(3) The individual has an annual household income of not more than two hundred twenty-five percent of the federal income poverty level;

(4) The individual is not eligible for health insurance coverage through the individual's employer;

(5) The individual has not had health insurance coverage for at least six months;

(6) The individual has household earned income that exceeds the maximum income for eligibility for Temporary Assistance for Needy Families (TANF) benefits.

2. The following individuals shall not be eligible for the program:

(1) An individual who participates in the federal Medicare program, 42 U.S.C. 1395, et seq.;

(2) A pregnant woman for purposes of pregnancy-related services who is eligible for health care coverage under chapter 208, RSMo;

(3) An individual who has resources or owns assets with a value in excess of two hundred twenty-five thousand dollars.

3. The eligibility requirements specified in subsection 1 of this section are subject to approval for federal financial participation by the United States Department of Health and Human Services.

4. The department shall provide for enrollment with the program through the department's Internet web site and family support division offices.

Section 3. 1. The program shall include the following medically necessary services in a manner and to the extent determined by the department:

(1) Inpatient hospital services;

(2) Outpatient hospital and ambulatory surgical center services;

(3) Emergency room services;

(4) Physician and advanced practice nurse services;

(5) Federally qualified health center and rural health clinic services;

(6) Laboratory, radiology, and other diagnostic services;

(7) Prescription drug coverage;

(8) Mental health and substance abuse treatment. The program shall not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions;

(9) Home health services;

(10) Durable medical equipment;

(11) Family planning services:

(a) Including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law, 42 U.S.C. 1396, et seq.; and

(b) Not including abortion or abortifacients, except as required in federal Medicaid law, 42 U.S.C. 1396, et seq.;

(12) Personal care services;

(13) Emergency ground and air transportation services;

(14) Hospice services;

(15) Prevention and wellness services; and

(16) Case management, care coordination, and disease management.

2. The program shall, at no cost to the individual, provide payment for two physician office visits and three hundred dollars of qualifying preventative care services per year for program participants. Any additional physician office visits or preventative care services covered under the program and received a participant during the year shall be subject to the deductible and copayment requirements of the program.

3. The program may include incentives designed to encourage and promote healthy lifestyle choices which are medically appropriate, age appropriate, and attainable for individual participants, taking into consideration any limitations on lifestyle choices which may exist based on medical conditions and the needs of the population serviced under the program.

4. The program shall, subject to appropriations, provide to an individual who participates in the program a list of health care services that qualify as preventive care services for the age, gender, and preexisting conditions of the individual. The program shall consult with the federal U.S. Preventive Services Task Force for a list of recommended preventive care services.

Section 4. 1. Every individual who participates in the program shall have an individual insure Missouri account to which payments may be made for the individual's participation in the program by any of the following:

(1) The individual;

(2) An employer;

(3) The state, including any incentive payments contributed by the state;

(4) Any philanthropic or charitable contributor.

2. The minimum funding amount for an individual insure Missouri account is the amount required under section 6 of this act.

3. An individual insure Missouri account shall be used to pay the individual's deductible and copayments for health care services under the program.

4. An individual may make payments to his or her individual insure Missouri account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this section and distributed equally throughout the calendar year;

(2) Submission of the individual's contribution under sections 1 to 8 of this act to the department to deposit in the participant's individual insure Missouri account in a manner prescribed by the department;

(3) Another method determined by the department.

5. An employer may make, from moneys not payable by the employer to the employee, not more than fifty percent of an individual's required payment to his or her individual insure Missouri account.

6. Any employer making any contributions for a participant in the insure Missouri program may make such contribution to the employee's individual insure Missouri account or may make such contribution towards the payment of any premiums for coverage of the employee under the program.

Section 5. 1. An individual's participation in the program shall not begin until an initial payment is made for the individual's participation in the program. A required payment to the program for the individual's participation shall not exceed one-twelfth of the annual payment required under subsection 2 of this section.

2. To participate in the program, an individual shall:

(1) Apply for the program in a manner prescribed by the department. The department may develop and allow a joint application for a household;

(2) If the individual is approved by the department to participate in the program, contribute to an individual insure Missouri account the lesser of the following:

(a) One thousand dollars per year or an amount not to exceed the deductible for the participant's coverage under the program, whichever is greater, less any amounts paid by the individual under:

a. The MO HealthNet program;

b. The children's health insurance program; and

c. The Medicare program, 42 U.S.C. 1395, et seq., as determined by the department; or

(b) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid under the MO HealthNet program, the

children's health insurance program, and the Medicare program, 42 U.S.C. 1395, et seq., as determined by the department:

a. One percent of the annual household income per year for incomes up to one hundred percent of the federal poverty level;

b. Two percent of the annual household income per year if the individual has an annual household income of more than one hundred percent and not more than one hundred twenty-five percent of the federal poverty level;

c. Three percent of the annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent and not more than one hundred fifty percent of the federal poverty level;

d. Four percent of the annual household income per year if the individual has an annual household income of more than one hundred fifty percent and not more than two hundred percent of the federal poverty level; or

e. Five percent of the annual household income per year if the individual has an annual household income of more than two hundred and not more than two hundred twenty-five percent of the federal poverty level.

3. If the individual's account does not have sufficient funds to pay any deductible or copayments incurred by an individual under the program, the state shall contribute to an individual's account all or any portion of such unmet deductibles and copayments incurred by an individual.

4. If the required payment to the program is not made within ninety days after the required payment date, the individual or individuals shall be terminated from participation in the program. The individual or individuals shall receive written notice before being terminated from the program.

5. If an individual is terminated from the program for fraud or under subsection 4 of this section, the individual shall not reapply for participation in the program within six months of termination.

Section 6. 1. An individual who is approved to participate in the program is eligible for a twelve-month program period unless the individual fails to make the required contribution. An individual who participates in the program without a break in service shall not be refused renewal of participation in the program:

(1) For the sole reason that the program has reached the program's maximum enrollment; or

(2) If the individual is eligible for transitional participation under subsection 3 of this section.

2. If the individual chooses to renew participation in the program, the individual shall complete a renewal application and any necessary documentation, and submit to the insure Missouri program the documentation and application on a form prescribed by the department. At the time of renewal under the program, a participant may change qualified plans for his or her receipt of benefits under the program.

3. If an individual is eligible and participates in the program without a break in service and such individual's income subsequently exceeds the current income limitations for participation in the program, based on appropriations, at the time of such individual's renewal, but otherwise remains eligible for participation in the program, the individual may choose and shall be eligible for transitional participation in the program; except that, such individual's participation in the program shall terminate if his or her income exceeds two hundred twenty-five percent of the federal poverty level. A transitional participant shall receive coverage under a qualified plan and shall be responsible for the required payments in the same manner established under the program in accordance with sections 1 to 8 of this act.

4. Any moneys remaining in an individual insure Missouri account of a participant who renews participation in the program at the end of the individual's twelve-month program period shall be used to reduce the individual's payments for the subsequent program period.

5. If an individual is no longer eligible for the program, does not renew participation in the program at the end of the program period or is terminated from the program for nonpayment of a required payment, the department shall, as determined by rule and not more than ninety days after the last date of participation in the program, refund to the individual the amount of any balance remaining in the individual insure Missouri account less any outstanding individual obligations under the program.

Section 7. 1. For individuals approved for participation in the program, health care coverage shall be obtained as follows:

(1) An individual approved for participation in the program shall seek health care coverage through a qualified plan available in the private individual health insurance market from insurance agents and brokers; or

(2) If an individual approved for participation in the program is denied coverage under two qualified plans available in the private individual health insurance market, the individual shall receive health care coverage through a qualified plan available in the health insurance pool in accordance with the provisions of sections 376.960 to 376.991, RSMo, established for such coverage.

2. The deductible for any qualified plan under the program shall not exceed two thousand five hundred dollars.

3. The premium required of the qualified plan shall be certified as actuarially sound in accordance with the requirements established by the federal Centers for Medicare and Medicaid Services.

4. Commission payments for the sale of qualified plans to individuals under the insure Missouri program shall be set by the department of social services. The insurance agent or broker shall comply with the federal Centers for Medicare and Medicaid Services requirements concerning marketing and plan enrollment for insure Missouri program participants eligible for federal participation.

5. The department of social services, in consultation and coordination with the department of insurance, financial institutions and professional registration and the board of directors for the health insurance pool, shall ensure that individuals approved for participation in the program are able to seek and obtain health insurance coverage under the program through insurance agents and brokers licensed in this state.

6. The department of social services, the department of insurance, financial institutions and professional registration, and the board of directors for the health insurance pool may promulgate rules and/or joint rules to implement 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 the effective date of this section shall be invalid and void.

7. No more than eighty-five percent of the individuals covered by any qualified insurance plan shall be members covered under the insure Missouri program.

Section 8. The department of social services shall promulgate rules and regulations for the implementation of sections 1 to 8 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 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. Sections 1 to 8 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 8 of this act shall be invalid and void.

Section 9. The provisions of section 208.227, RSMo, shall apply to any additional geographic areas of the state or populations covered and designated after the effective date of this section to receive MO HealthNet benefits through a health improvement plan other than fee-for-service.

Section 10. The professional services payment committee created by section 208.197, RSMo, shall review and make recommendations to the MO HealthNet division regarding standards and policies for denying or withholding payment to a health care provider for treatment costs associated with preventable errors, injuries and infections occurring under that provider's care. The recommendations shall include a list of medical incidents proposed to be included in the payment prohibition, which shall include those incidents for which the federal Centers for Medicare and Medicaid Services will not make payment under the Medicare program or all or some serious reportable events in health care as defined in section 197.551, RSMo. Such recommendations shall be completed and issued by the committee to the division by December 31, 2008, or six months after the committee is appointed with the advice and consent of the senate, whichever occurs later. After reviewing the recommendations of the committee, the MO HealthNet division may promulgate regulations pursuant to chapter 536, RSMo, to implement such payment restrictions.

Section 11. Any health benefit plan as defined in section 376.1350, RSMo, third party administrator, administrative service organization, and pharmacy benefits manager, shall process and pay all properly submitted medical assistance subrogation claims or MO HealthNet subrogation claims for a period of three years from the date the services were provided or rendered, regardless of any other timely filing requirement otherwise imposed by such entity and the entity shall not deny such claims on the basis of the type or format of the claim form, or a failure to present proper documentation of coverage at the point of sale.

Section 12. In implementing the provisions related to coverage of the uninsured and payments to providers for providing care to the uninsured under sections 1 to 8 of this act and under the MO HealthNet program, the MO HealthNet division shall take into consideration the special needs of Missouri's Tier I Safety Net providers so that they are not disproportionately impacted by rules promulgated by the division as it implements the provisions of such programs.

[143.113. 1. For all taxable years beginning on or after January 1, 2000, an individual taxpayer who is an employee within the meaning of Section 401(c)(1) of the Internal Revenue Code of 1986, as amended, shall be allowed to

subtract from the taxpayer's Missouri adjusted gross income to determine Missouri taxable income an amount equal to the amount which the taxpayer has paid during the taxable year for insurance which constitutes medical care for the taxpayer, the taxpayer's spouse, and dependents to the extent that such amounts qualify as deductible pursuant to Section 162(l) of the Internal Revenue Code of 1986, as amended, for the same taxable year, and shall only be deductible to the extent that such amounts are not deducted on the taxpayer's federal income tax return for that taxable year.

2. The director of the department of revenue shall promulgate rules and regulations to administer the provisions of this section. No rule or portion of a rule promulgated pursuant to the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of chapter 536, RSMo.**]**

[191.400. 1. There is hereby created a "State Board of Health" which shall consist of seven members, who shall be appointed by the governor, by and with the advice and consent of the senate. No member of the state board of health shall hold any other office or employment under the state of Missouri other than in a consulting status relevant to the member's professional status, licensure or designation. Not more than four of the members of the state board of health shall be from the same political party.

2. Each member shall be appointed for a term of four years; except that of the members first appointed, two shall be appointed for a term of one year, two for a term of two years, two for a term of three years, and one for a term of four years. The successors of each shall be appointed for full terms of four years. No person may serve on the state board of health for more than two terms. The terms of all members shall continue until their successors have been duly appointed and qualified. Three of the persons appointed to the state board of health shall be persons who are physicians and surgeons licensed by the state board of registration for the healing arts of Missouri. One of the persons appointed to the state board of health shall be a dentist licensed by the Missouri dental board. One of the persons appointed to the state board of health shall be a chiropractic physician licensed by the Missouri state board of chiropractic examiners. Two of the persons appointed to the state board of health shall be persons other than those licensed by the state board of registration for the healing arts, the Missouri dental board, or the Missouri state board of chiropractic examiners and shall be representative of those persons, professions and businesses which are regulated and supervised by the department of health and senior services and the state board of health. If a vacancy occurs in the appointed membership, the governor may appoint a member for the remaining portion of the unexpired term created by the vacancy. If the vacancy occurs while the senate is not in session, the governor shall make a temporary appointment subject to the approval of the senate when it next convenes. The members shall receive actual and necessary expenses plus twenty-five dollars per day for each day of actual attendance.

3. The board shall elect from among its membership a chairperson and a vice chairperson, who shall act as chairperson in his or her absence. The board shall meet at the call of the chairperson. The chairperson may call meetings at such times as he or she deems advisable, and shall call a meeting when requested to do so by three or more members of the board.**]**

[192.014. The state board of health shall advise the department of health and senior services in the:

(1) Promulgation of rules and regulations by the department of health and senior services. At least sixty days before the rules and regulations prescribed by the department or any subsequent changes in them become effective, a copy shall be filed in the office of the secretary of state. All rules and regulations promulgated by the department shall, as soon as practicable after their adoption, be submitted to the general assembly. The rules and regulations shall continue in force and effect until disapproved by the general assembly;

(2) Formulation of the budget for the department of health and senior services;

(3) Planning for and operation of the department of health and senior services.**]**

[376.973. 1. Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. The total cost of pool operation shall be the amount by which all program expenses, including pool expenses of administration, incurred losses for the year, and other appropriate losses exceeds all program revenues, including net premiums, investment income, and other appropriate gains.

2. Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and one hundred ten percent of all claims paid by insurance arrangements in the state during the preceding calendar year; provided, however, that the assessment for each health maintenance organization shall be determined through the application of an equitable formula based upon the value of services provided in the preceding calendar year.

3. Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation calculated under subsection 1 of this

section by a fraction, the numerator of which equals one hundred ten percent of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and one hundred ten percent of all benefits paid by insurance arrangements made on behalf of insureds in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the director.

4. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not paid claims.**]**

[376.975. Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it. Any deficit incurred by the pool shall be recouped by assessments apportioned as provided in subsections 1, 2, and 3 of section 376.973 by the board among members. The amount of assessments incurred by each member of the pool shall be allowed as an offset against certain taxes, and shall be subject to certain limitations, as follows: Each pool member subject to chapter 148, RSMo, may deduct from premium taxes payable for any calendar year to the state any and all assessments paid for the same year pursuant to sections 376.960 to 376.989. All assessments, for a fiscal year, shall not exceed the net premium tax due and payable by such member in the previous year. If the assessment exceeds any premium tax due or payable in such year, the excess shall be a credit or offset carried forward against any premium tax due or payable in succeeding years until the excess is exhausted.**]**

[376.980. Each pool member exempt from chapter 148, RSMo, shall be allowed to offset against any sales or use tax on purchases due, paid, or payable in the calendar year in which such assessments are made. Further, such assessment, for any fiscal year, shall not exceed one percent of nongroup premium income, exclusive of Medicare supplement programs, received in the previous year. If the assessment exceeds the part of any sales tax or use tax due or payable in such year, the excess shall be a credit or offset carried forward against the part of any sales tax or use tax due or payable in succeeding years until the excess is exhausted. The director of revenue, in consultation with the board, shall promulgate and enforce reasonable rules and regulations and prescribe forms for the administration and enforcement of this law.**]**

[376.984. The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the

assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessment set forth in subsections 1, 2, and 3 of section 376.973. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for four years.**]**

[376.990. The board of directors of the state health insurance pool is hereby directed to conduct a study regarding the financing of the state health insurance pool. Such study shall include, but not be limited to, research and findings of how other states finance their state high-risk pools. The study shall consider alternative assessment approaches to the current assessment method employed in section 376.975. In addition to studying alternative financing mechanisms employed by other state high-risk pools, the board shall explore the ramifications of eliminating or reducing a carrier's ability to offset their assessments against their premium tax liability. The polestar of the study shall be establishing a stable funding source for the Missouri state health insurance pool while providing adequate health insurance coverage to Missouri's uninsurable population. The board of directors of the state health insurance pool shall submit a report of its findings and recommendations to each member of the general assembly no later than January 1, 2008.**]**

[660.062. 1. There is hereby created a "State Board of Senior Services" which shall consist of seven members, who shall be appointed by the governor, by and with the advice and consent of the senate. No member of the state board of senior services shall hold any other office or employment under the state of Missouri other than in a consulting status relevant to the member's professional status, licensure or designation. Not more than four of the members of the state board of senior services shall be from the same political party.

2. Each member shall be appointed for a term of four years; except that of the members first appointed, two shall be appointed for a term of one year, two for a term of two years, two for a term of three years and one for a term of four years. The successors of each shall be appointed for full terms of four years. No person may serve on the state board of senior services for more than two terms. The terms of all members shall continue until their successors have been duly appointed and qualified. One of the persons appointed to the state board of senior services shall be a person currently working in the field of gerontology. One of the persons appointed to the state board of senior services shall be a physician with expertise in geriatrics. One of the persons appointed to the state board of senior services shall be a person with expertise in nutrition. One of the persons appointed to the state board of senior services shall be a person with expertise in rehabilitation services of persons with disabilities. One of the

persons appointed to the state board of senior services shall be a person with expertise in mental health issues. In making the two remaining appointments, the governor shall give consideration to individuals having a special interest in gerontology or disability-related issues, including senior citizens. Four of the seven members appointed to the state board of senior services shall be members of the governor's advisory council on aging. If a vacancy occurs in the appointed membership, the governor may appoint a member for the remaining portion of the unexpired term created by the vacancy. The members shall receive actual and necessary expenses plus twenty-five dollars per day for each day of actual attendance.

3. The board shall elect from among its membership a chairman and a vice chairman, who shall act as chairman in his or her absence. The board shall meet at the call of the chairman. The chairman may call meetings at such times as he or she deems advisable, and shall call a meeting when requested to do so by three or more members of the board.

4. The state board of senior services shall advise the department of health and senior services in the:

(1) Promulgation of rules and regulations by the department of health and senior services;

(2) Formulation of the budget for the department of health and senior services; and

(3) Planning for and operation of the department of health and senior services.**]**

Section B. Because immediate action is necessary to ensure adequate provision of health care services to the low-income citizens of this state, the enactment of section 376.985, subsections 6 and 7 of section 376.986 and sections 1 to 8 of section A of this act are 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 376.985, subsections 6 and 7 of section 376.986 and sections 1 to 8 of section A of this act shall be in full force and effect July 1, 2008, or upon its passage and approval, whichever later occurs.

Section C. Sections 148.380, 376.960, 376.966, 376.981, and 376.983, subsections 1 to 5 and 8 to 12 of section 376.986, and section 376.991, and the repeal of sections 376.973, 376.975, 376.980, 376.984, and 376.990 of section A of this act shall become effective January 1, 2009.

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