SECOND REGULAR SESSION

HOUSE BILL NO. 2398

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE SCHAAF.

Read 1st time March 11, 2008 and copies ordered printed.

D. ADAM CRUMBLISS, Chief Clerk

5477L.01I

AN ACT

To repeal sections 197.310, 197.330, 208.955, and 374.184, RSMo, and to enact in lieu thereof twenty-one new sections relating to the insure Missouri plan, with penalty provisions.

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

Section A. Sections 197.310, 197.330, 208.955, and 374.184, RSMo, are repealed and twenty-one new sections enacted in lieu thereof, to be known as sections 197.310, 197.330, 208.955, 208.1300, 208.1303, 208.1306, 208.1309, 208.1312, 208.1315, 208.1318, 208.1321, 208.1324, 208.1327, 208.1330, 208.1333, 208.1336, 208.1339, 208.1345, 374.184, 376.1460, and 376.1465, to read as follows:

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**] One member who is professionally qualified in health insurance plan sales and administration**; and

(2) **[**Two members of the house of representatives appointed by the speaker, who shall be from different political parties**] One member who has professionally qualified experience in commercial development, financing, and lending**; and

(3) **[**Five members**] Two members with a doctorate of philosophy in economics;**

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.

(4) Two members who are professionally qualified as medical doctors or doctors of osteopathy, but who are not employees of a hospital or consultants to a hospital;

(5) Two members who are professionally experienced in hospital administration, but are not employed by a hospital or as consultants to a hospital;

(6) One member who is a registered nurse, but who is not an employee of a hospital or a consultant to a hospital.

All members shall be appointed by the governor with the advice and consent of the senate, not more than **[**three**] five** of whom shall be from the same political party. **All members shall serve four-year terms.**

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

[8.**] 7.** 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.

197.330. 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) 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;

(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, subpoena witnesses, and compel the attendance of witnesses, the giving of testimony, and the production of records;

(3) All ex parte communications between members of the committee and any interested party or witness which are related to the subject matter of a hearing shall be prohibited at any time prior to, during, or after such hearing;

(4) The provisions of sections 105.452 to 105.458, RSMo, regarding conflict of interest shall apply;

(5) In all hearings, there shall be a rebuttable presumption of the need for additional medical services and lower costs for such medical services in the affected region or community. Any party opposing the issuance of a certificate of need shall have the burden of proof to show by clear and convincing evidence that no such need exists or that

the new facility will cause a substantial and continuing loss of medical services within the affected region or community;

(6) 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 in any proceeding nor in the manner of taking testimony before the committee shall invalidate any decision made by the committee; and

(7) The committee shall have the authority, upon a majority vote of the committee, to assess the costs of court reporting transcription or the issuance of subpoenas to one or both of the parties to the proceedings.

208.955. 1. There is hereby established in the department of social services the "MO HealthNet Oversight Committee", which shall be appointed by January 1, 2008, and shall consist of **[**eighteen**]** **twenty-two** members as follows:

(1) Two members of the house of representatives, one from each party, appointed by the speaker of the house of representatives and the minority floor leader of the house of representatives;

(2) Two members of the Senate, one from each party, appointed by the president pro tem of the senate and the minority floor leader of the senate;

(3) One consumer representative;

(4) Two primary care physicians, licensed under chapter 334, RSMo, recommended by any Missouri organization or association that represents a significant number of physicians licensed in this state, who care for participants, not from the same geographic area;

(5) Two physicians, licensed under chapter 334, RSMo, who care for participants but who are not primary care physicians and are not from the same geographic area, recommended by any Missouri organization or association that represents a significant number of physicians licensed in this state;

(6) **One podiatrist, licensed under chapter 330, RSMo, who cares for participants. The podiatrist shall be recommended by any Missouri organization or association that represents a significant number of podiatrists licensed in this state;**

(7) One nurse, licensed under chapter 335, RSMo, who cares for participants. The nurse shall be recommended by any Missouri organization or association that represents a significant number of nurses in this state;

(8) One representative of the state hospital association;

[(7)**]** **(9)** One nonphysician health care professional who cares for participants, recommended by the director of the department of insurance, financial institutions and professional registration;

[(8)**] (10)** One dentist, who cares for participants. The dentist shall be recommended by any Missouri organization or association that represents a significant number of dentists licensed in this state;

[(9)**] (11)** Two patient advocates;

[(10)**] (12)** One public member; **[**and

(11)**] (13) Two representatives of rural health clinics; and**

(14) The directors of the department of social services, the department of mental health, the department of health and senior services, or the respective directors' designees, who shall serve as ex-officio members of the committee.

2. The members of the oversight committee, other than the members from the general assembly and ex-officio members, shall be appointed by the governor with the advice and consent of the senate. A chair of the oversight committee shall be selected by the members of the oversight committee. Of the members first appointed to the oversight committee by the governor, eight members shall serve a term of two years, seven members shall serve a term of one year, and thereafter, members shall serve a term of two years. Members shall continue to serve until their successor is duly appointed and qualified. Any vacancy on the oversight committee shall be filled in the same manner as the original appointment. Members shall serve on the oversight committee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of social services for that purpose. The department of social services shall provide technical, actuarial, and administrative support services as required by the oversight committee. The oversight committee shall:

(1) Meet on at least four occasions annually, including at least four before the end of December of the first year the committee is established. Meetings can be held by telephone or video conference at the discretion of the committee;

(2) Review the participant and provider satisfaction reports and the reports of health outcomes, social and behavioral outcomes, use of evidence-based medicine and best practices as required of the health improvement plans and the department of social services under section 208.950;

(3) Review the results from other states of the relative success or failure of various models of health delivery attempted;

(4) Review the results of studies comparing health plans conducted under section 208.950;

(5) Review the data from health risk assessments collected and reported under section 208.950;

(6) Review the results of the public process input collected under section 208.950;

(7) Advise and approve proposed design and implementation proposals for new health improvement plans submitted by the department, as well as make recommendations and suggest modifications when necessary;

(8) Determine how best to analyze and present the data reviewed under section 208.950 so that the health outcomes, participant and provider satisfaction, results from other states, health plan comparisons, financial impact of the various health improvement plans and models of care, study of provider access, and results of public input can be used by consumers, health care providers, and public officials;

(9) Present significant findings of the analysis required in subdivision (8) of this subsection in a report to the general assembly and governor, at least annually, beginning January 1, 2009;

(10) Review the budget forecast issued by the legislative budget office, and the report required under subsection (22) of subsection 1 of section 208.151, and after study:

(a) Consider ways to maximize the federal drawdown of funds;

(b) Study the demographics of the state and of the MO HealthNet population, and how those demographics are changing;

(c) Consider what steps are needed to prepare for the increasing numbers of participants as a result of the baby boom following World War II;

(11) Conduct a study to determine whether an office of inspector general shall be established. Such office would be responsible for oversight, auditing, investigation, and performance review to provide increased accountability, integrity, and oversight of state medical assistance programs, to assist in improving agency and program operations, and to deter and identify fraud, abuse, and illegal acts. The committee shall review the experience of all states that have created a similar office to determine the impact of creating a similar office in this state; **[**and**]**

(12) **Approve health insurance plans for the insure Missouri plan established under sections 376.1300 to 376.1345, RSMo; and**

(13) Perform other tasks as necessary, including but not limited to making recommendations to the division concerning the promulgation of rules and emergency rules so that quality of care, provider availability, and participant satisfaction can be assured.

3. By July 1, 2011, the oversight committee shall issue findings to the general assembly on the success and failure of health improvement plans and shall recommend whether or not any health improvement plans should be discontinued.

4. The oversight committee shall designate a subcommittee devoted to advising the department on the development of a comprehensive entry point system for long-term care that shall:

(1) Offer Missourians an array of choices including community-based, in-home, residential and institutional services;

(2) Provide information and assistance about the array of long-term care services to Missourians;

(3) Create a delivery system that is easy to understand and access through multiple points, which shall include but shall not be limited to providers of services;

(4) Create a delivery system that is efficient, reduces duplication, and streamlines access to multiple funding sources and programs;

(5) Strengthen the long-term care quality assurance and quality improvement system;

(6) Establish a long-term care system that seeks to achieve timely access to and payment for care, foster quality and excellence in service delivery, and promote innovative and cost-effective strategies; and

(7) Study one-stop shopping for seniors as established in section 208.612.

5. The subcommittee shall include the following members:

(1) The lieutenant governor or his or her designee, who shall serve as the subcommittee chair;

(2) One member from a Missouri area agency on aging, designated by the governor;

(3) One member representing the in-home care profession, designated by the governor;

(4) One member representing residential care facilities, predominantly serving MO HealthNet participants, designated by the governor;

(5) One member representing assisted living facilities or continuing care retirement communities, predominantly serving MO HealthNet participants, designated by the governor;

(6) One member representing skilled nursing facilities, predominantly serving MO HealthNet participants, designated by the governor;

(7) One member from the office of the state ombudsman for long-term care facility residents, designated by the governor;

(8) One member representing Missouri centers for independent living, designated by the governor;

(9) One consumer representative with expertise in services for seniors or the disabled, designated by the governor;

(10) One member with expertise in Alzheimer's disease or related dementia;

(11) One member from a county developmental disability board, designated by the governor;

(12) One member representing the hospice care profession, designated by the governor;

(13) One member representing the home health care profession, designated by the governor;

(14) One member representing the adult day care profession, designated by the governor;

(15) One member gerontologist, designated by the governor;

(16) Two members representing the aged, blind, and disabled population, not of the same geographic area or demographic group designated by the governor;

(17) The directors of the departments of social services, mental health, and health and senior services, or their designees; and

(18) One member of the house of representatives and one member of the senate serving on the oversight committee, designated by the oversight committee chair.

Members shall serve on the subcommittee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of health and senior services for that purpose. The department of health and senior services shall provide technical and administrative support services as required by the committee.

6. By October 1, 2008, the comprehensive entry point system subcommittee shall submit its report to the governor and general assembly containing recommendations for the implementation of the comprehensive entry point system, offering suggested legislative or administrative proposals deemed necessary by the subcommittee to minimize conflict of interests for successful implementation of the system. Such report shall contain, but not be limited to, recommendations for implementation of the following consistent with the provisions of section 208.950:

(1) A complete statewide universal information and assistance system that is integrated into the web-based electronic patient health record that can be accessible by phone, in-person, via MO HealthNet providers and via the Internet that connects consumers to services or providers and is used to establish consumers' needs for services. Through the system, consumers shall be able to independently choose from a full range of home, community-based, and facility-based health and social services as well as access appropriate services to meet individual needs and preferences from the provider of the consumer's choice;

(2) A mechanism for developing a plan of service or care via the web-based electronic patient health record to authorize appropriate services;

(3) A preadmission screening mechanism for MO HealthNet participants for nursing home care;

(4) A case management or care coordination system to be available as needed; and

(5) An electronic system or database to coordinate and monitor the services provided which are integrated into the web-based electronic patient health record.

7. Starting July 1, 2009, and for three years thereafter, the subcommittee shall provide to the governor, lieutenant governor and the general assembly a yearly report that provides an

update on progress made by the subcommittee toward implementing the comprehensive entry point system.

8. The provisions of section 23.253, RSMo, shall not apply to sections 208.950 to 208.955.

208.1300. As used in sections 208.1300 to 208.1345, the following terms shall mean:

(1) "Plan", the insure Missouri plan established in section 208.1303;

(2) "Preventative care services", care that is provided to an individual to prevent disease, diagnose disease, or promote good health.

208.1303. 1. There is hereby established the "Insure Missouri Plan" within the MO HealthNet division of the department of social services.

2. The department of insurance, financial institutions and professional registration and the MO HealthNet division of the department of social services shall provide oversight of the marketing practices of the plan.

3. The MO HealthNet division shall promote the plan and provide information to potential eligible individuals.

4. The MO HealthNet division shall, to the extent possible, ensure that enrollment in the plan is distributed throughout Missouri in proportion to the number of individuals throughout Missouri who are eligible for participation in the plan.

5. The MO HealthNet division 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.

208.1306. 1. The plan shall provide for every participating individual a health care home.

2. The plan shall include the following medically necessary services in a manner and to the extent determined by the MO HealthNet division:

(1) Mental health care services;

(2) Inpatient hospital services;

(3) Prescription drug coverage;

(4) Emergency room services;

(5) Physician and advanced practice nurse services;

(6) Diagnostic services;

(7) Outpatient services;

(8) Home health services;

(9) Urgent care center services;

(10) Preventative care services;

(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) Hospice services;

(13) Substance abuse services;

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

(15) Durable medical equipment;

(16) Emergency transportation services;

(17) Personal care services;

(18) Case management, care coordination and disease management.

3. The plan may 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.

208.1309. 1. The plan shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The plan shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

2. The plan shall, at no cost to the individual, provide payment for at least five hundred dollars of qualifying preventative care services per year for an individual who participates in the plan. Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

208.1312. At least eighty-five percent of the funds appropriated by the general assembly for the plan shall be used to fund payment for health care services.

208.1315. The plan is not an entitlement program for noncustodial parents, custodial parents, or other individuals with incomes over eighty-five percent of the federal poverty level. The maximum enrollment of individuals who may participate in the plan is dependent on funding appropriated for the plan by the general assembly. Eligibility for the plan may be phased in incrementally based on appropriations by the general assembly.

208.1318. 1. An individual is eligible for participation in the plan 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 and has been a resident of Missouri for at least twelve months;

(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 Temporary Assistance for Needy Families benefits.

2. The following individuals are not eligible for the plan:

(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.

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.

208.1321. 1. Individuals with incomes over eighty-five percent of the federal poverty level who participate in the plan shall have a health care account to which payments may be made for the individual's participation in the plan by any of the following:

(1) The individual;

(2) An employer;

(3) The state;

(4) Any philanthropic or charitable contributor.

2. The minimum funding amount for a health care account is the amount required under section 208.1327.

3. An individual's health care account shall be used to pay the individual's deductible for health care services under the plan.

4. An individual may make payments to the individual's health care 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 208.1300 to 208.1345 to the MO HealthNet division to deposit in the individual's health care account in a manner prescribed by the division;

(3) Another method determined by the division.

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 the individual's health care account.

208.1324. 1. An individual's participation in the plan does not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan 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 plan, an individual shall:

(1) Apply for the plan in a manner prescribed by the department of social services. The department of social services may develop and allow a joint application for a household;

(2) If the individual is approved by the division to participate in the plan, contribute to the individual's health care account the lesser of the following:

(a) One thousand dollars per year, 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 of social services; or

(b) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual 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 of social services:

a. One percent of the individual's annual household income per year if the individual has an annual household income of more than eighty-five percent and not more than one hundred percent of the federal income poverty level;

b. Two percent of the individual's 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 income poverty level;

c. Three percent of the individual's 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 income poverty level;

d. Four percent of the individual's 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 income poverty level; or

e. Five percent of the individual's 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 income poverty level.

3. The state shall contribute the difference to the individual's account if the individual's payment required under subdivision (2) of subsection 2 of this section is less than one thousand dollars. The state contribution shall be contributed in twelve monthly deposits; except that, the first deposit made to an individual's account shall be equal to twenty percent of the total state contributions to be made to the individual's account.

4. If an individual's required payment to the plan is not made within sixty days after the required payment date, the individual may be terminated from participation in the plan. The individual shall receive written notice before the individual is terminated from the plan.

5. After termination from the plan under subsection 4 of this section, the individual may reapply to participate in the plan.

208.1327. 1. An individual who is approved to participate in the plan is eligible for a twelve-month plan period. An individual who participates in the plan without a break in service may not be refused renewal of participation in the plan for the sole reason that the plan has reached the plan's maximum enrollment.

2. If the individual chooses to renew participation in the plan, the individual shall complete a renewal application and any necessary documentation, and submit to the insure Missouri plan the documentation and application on a form prescribed by the MO HealthNet division.

3. Any moneys remaining in the health care account of an individual who renews participation in the plan at the end of the individual's twelve-month plan period shall be used to reduce the individual's payments for the subsequent plan period.

4. If an individual is no longer eligible for the plan, does not renew participation in the plan at the end of the plan period, or is terminated from the plan for nonpayment of a required payment, the MO HealthNet division shall, not more than ninety days after the last date of participation in the plan, refund to the individual the amount of any

individual payments remaining in the individual's health care account as determined by rule.

208.1330. 1. An insurer or health maintenance organization that contracts with the MO HealthNet division to provide health insurance coverage to an individual that participates in the plan:

(1) Is responsible for the claim processing for the coverage;

(2) Is responsible for provider reimbursement; and

(3) Shall not deny coverage to an eligible individual who has been approved by the MO HealthNet division to participate in the plan.

2. An insurer or a health maintenance organization that contracts with the MO HealthNet division to provide health insurance coverage under the plan shall incorporate cultural competency standards established by the office. The standards shall include standards for non-English speaking, minority, and disabled populations.

3. The deductible for any qualified plan under the program shall not exceed two thousand five hundred dollars.

208.1333. 1. An insurer or a health maintenance organization that contracts with the MO HealthNet division to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the MO HealthNet division to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

(1) Has not had health insurance coverage during the previous six months; and

(2) Meets the eligibility requirements specified in section 208.1318 for participation in the plan but is not enrolled because the plan has reached maximum enrollment.

2. The insurance underwriting and rating practices applied to health insurance coverage offered under subsection 1 of this section shall not be different from underwriting and rating practices used for the health insurance coverage provided under the plan.

3. The state shall not provide funding for health insurance coverage received under this section.

208.1336. The MO HealthNet division shall promulgate rules and regulations for the implementation of sections 208.1300 to 208.1345. 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 208.1300 to 208.1345 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.

208.1339. Any participant in the plan who is medically uninsurable shall receive health insurance coverage through the health insurance pool established under sections 376.960 to 379.990, RSMo.

208.1345. 1. The MO HealthNet division 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 plan. Such waiver shall include the following provisions:

(1) Requiring participants to establish a health care account in which the participant and the state shall deposit moneys that can be used by the participant for health care expenses and premiums;

(2) Allows any individual health plan available in the private market that meets the criteria established for a plan under the insure Missouri plan to be available to participants in the plan.

2. Prior to the submission of an application for a federal waiver under subsection 1 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 and recommendations.

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**.

376.1460. 1. The department of health and senior services shall promulgate rules governing switch communications from health benefit plans, as defined in section 376.1350, to patients. As used in this section, "switch communication" means a communication that recommends a patient's medication be switched to a different medication than the medication originally prescribed by the primary health care professional.

2. Such rules shall include, but not be limited to the following:

(1) Requirements for review and approval of switch communications by the department;

(2) Procedures for verifying the accuracy of any switch communications from health benefit plans to ensure that such switch communications are truthful, accurate, and not misleading;

(3) A requirement that all switch communications bear a prominent legend on the first page that states: "This is not a product safety notice. This is a promotional

announcement from your health care insurer about one of your current prescribed medications.";

(4) A requirement that, if the switch communication contains information regarding a potential therapeutic substitution, such communication shall explain that medications in the same therapeutic class are associated with different risks and benefits and may work differently in different patients.

3. All switch communications to patients shall clearly disclose any financial interest that the health care insurer, pharmacy benefits manager (PBM), prescriber, or any agent of such insurer, manager, or prescriber, has in the patient's decision to switch medications. In particular, cash or in-kind compensation payable to prescribers or their professional practices for switching patients from their currently prescribed medication to a different medication shall be disclosed to the patient.

4. 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.

376.1465. 1. Issuing or delivering or causing to be issued or delivered a switch communication that has not been approved and is not in compliance with the requirements of section 376.1460 is punishable by a fine not to exceed twenty-five thousand dollars.

2. Providing a misrepresentation or false statement in a switch communication under section 376.1460 is punishable by a fine not to exceed twenty-five thousand dollars.

3. Any other material violation of section 376.1460 is punishable by a fine not to exceed twenty-five thousand dollars.

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