HCS HB 2413, 2355, 2394 & 2398 -- TRANSFORMATION OF THE HEALTH CARE MARKET

SPONSOR: Schaaf

COMMITTEE ACTION: Voted "do pass" by the Special Committee on Healthcare Transformation by a vote of 6 to 2.

This substitute changes the laws regarding the health care market and services in Missouri and establishes the Insure Missouri Plan in the MO HealthNet Division within the Department of Social Services.

TRANSPARENCY OF HEALTH CARE SERVICES

The substitute requires health care providers and insurers, upon request, to provide patients with the information necessary to compare cost data for an ordered or planned service. These provisions do not apply to health care services delivered on an emergency basis, requests regarding services to be performed as part of ongoing inpatient care, or services represented by certain codes published by the American Medical Association. By January 1, 2009, the Department of Insurance, Financial Institutions, and Professional Registration is required to provide on its web site the Medicare fee schedule, by code and provider, for all Missouri Medicare providers and, for each Missouri hospital, the Medicare diagnosis-related group payment for each code. Compliance with this section will not be considered a violation of any provider contract provisions with a health carrier that prohibit disclosure of the provider's fee schedule with a health carrier to third parties.

Criteria is established for insurers to use in programs that publicly assess and compare quality and cost efficiency of health care data. A provider cannot decline to enter into a provider contract with an insurer solely because the insurer uses quality and cost efficiency of health care data programs.

A person who sells or distributes health care quality and cost efficiency data in a comparative format to the public is required to identify the source used to confirm the validity of the data and its analysis as an objective indicator of health care quality. This provision does not apply to articles or research studies that are published in peer-reviewed academic journals. The Department of Health and Senior Services is required to investigate complaints of alleged violations and is authorized to impose a penalty of up to $1,000.

Alleged violations by health insurers will be investigated and enforced by the Department of Insurance, Financial Institutions,

and Professional Registration.

MISSOURI HEALTH FACILITIES REVIEW COMMITTEE

Currently, the Missouri Health Facilities Review Committee for the Certificate of Need Program is composed of two members of the Senate, two members of the House of Representatives, and five members appointed by the Governor. The substitute changes the membership of the committee to:

(1) One member who is professionally qualified in health insurance plan sales and administration;

(2) One member who has professionally qualified experience in commercial development, financing, and lending;

(3) Two members with a doctorate of philosophy in economics;

(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; and

(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 will be appointed by the Governor with the advice and consent of the Senate and serve a four-year term. No more than five members can be from the same political party.

For all hearings held by the committee, the substitute:

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

(2) Specifies that the committee can, upon a majority vote of the committee, subpoena witnesses and require the attendance of witnesses, the giving of testimony, and the production of records;

(3) Prohibits all ex parte communications between members of the committee and any interested party or witness regarding the subject matter of the hearing at any time prior to, during, or after the hearing;

(4) Requires any party opposing the issuance of a certificate of need to show by clear and convincing evidence that the need does

not exist or that the new facility will cause a substantial and continuing loss of medical services within the affected region or community;

(5) Specifies that all committee hearings will be governed by rules adopted by the committee but not be bound by the technical rules of evidence; and

(6) Authorizes the committee, upon a majority vote, to assess the costs of court reporting transcription or the issuance of subpoenas to one or both of the involved parties.

The substitute removes the $1,000 fee that currently is required when filing a certificate of need application.

STANDARDIZED INSURANCE APPLICATIONS

The Director of the Department of Insurance, Financial Institutions, and Professional Registration must establish by rule uniform insurance application forms to be used by all insurers.

MISSOURI HEALTH INSURANCE POOL

The substitute:

(1) Increases the lifetime benefit cap for an individual covered under the Missouri Health Insurance Pool (MHIP) from $1 million to $2 million;

(2) Requires all health insurers to notify an insured person when he or she has exhausted 95% of his or her total lifetime health insurance benefits and the person's eligibility for and the methods of applying for coverage under the pool. Notification must be repeated when an insured has exhausted 100% of his or her total lifetime health insurance benefits;

(3) Reduces the pre-existing condition waiting period from 12 months to six months;

(4) Requires the pool to offer stop-loss coverage for any insurer in the private individual health insurance market to cover claim liability for an insured person who becomes uninsurable or an uninsurable dependent and to establish a two-year pilot program that offers small group stop-loss coverage to stabilize small group premiums when risks associated with specific individuals under a small group policy would result in increased premiums for the entire group. The MHIP board is required to submit a report to the General Assembly by January 1, 2011, regarding the pilot program and any recommendations to

expand the program statewide;

(5) Allows the MHIP board to establish a premium subsidy program for low-income individuals;

(6) Requires the pool, beginning July 1, 2008, to offer at least one plan that meets the criteria of the federal Centers for Medicare and Medicaid for uninsurable individuals eligible under the Insure Missouri Program;

(7) Establishes premium rates for health insurance coverage through the pool. For individuals with incomes of less than 300% of the federal poverty level, the premium will be equal to the standard risk rate. For individuals with incomes of 300% or more of the federal poverty level, the premium will be a sliding scale rate based on his or her income of between 100% and 125% of the standard risk rate;

(8) Specifies that any licensed insurance agent or broker who sells a health insurance policy offered under the pool to an eligible individual will receive a commission for the sale at an amount to be set by the board; and

(9) Eliminates insurer assessments under the pool and distributes premium taxes currently collected from insurers offering health-related insurance products to the pool beginning January 1, 2009.

INSURE MISSOURI PROGRAM

The substitute:

(1) Establishes the Insure Missouri Program within the Department of Social Services to provide health care coverage to low-income working Missourians;

(2) Requires the department to apply to the United States Department of Health and Human Services for a waiver and/or a Medicaid state plan amendment to develop and implement the program and to submit the proposed application to the Joint Committee on MO HealthNet for its review, recommendations, and approval;

(3) Specifies that the program is not an entitlement program. The maximum enrollment of program participants is dependent on the moneys appropriated by the General Assembly, and eligibility for the program can be phased in incrementally based on appropriations;

(4) Requires the department to establish certain specified

standards for consumer protection;

(5) Requires the program to pay 100% of the premium costs for participants, except for any participant whose health care account balance exceeds the annual required contribution amount. The amount in excess of the annual required amount will go toward payment of the participant's premium costs under the program;

(6) Specifies eligibility requirements for program participants and requires them to be subject to approval by the United States Department of Health and Human Services;

(7) Specifies covered, medically necessary services and that the program can include incentives designed to promote and encourage healthy lifestyles;

(8) Establishes a health care account for each eligible individual into which payments for his or her participation can be made by the individual, an employer, the state, or any philanthropic or charitable contributor. The account will be used to pay the individual's deductible under the program;

(9) Specifies that an individual's participation in the program does not begin until the participant makes an initial payment of at least one-twelfth of the annual required payment;

(10) Specifies that a participant's annual required payment is the lesser of $1,000 less any payments under the Mo HealthNet Program, the Children's Health Insurance Program, and the federal Medicare Program or a certain percentage of his or her household income;

(11) Requires the state to contribute the difference to the participant's account if his or her account does not have sufficient funds to pay any deductible or co-payments;

(12) Specifies that a participant will be terminated from participation in the plan if his or her required payment is not made within 90 days after the required date. Written notice must be given before a participant can be terminated from the plan;

(13) Specifies that approved participants are eligible for a 12-month period but must file a renewal application to remain in the program;

(14) Specifies that an eligible individual who participates in the program without a break in service and has an income exceeding the current income limit for participation, set by appropriations, at the time of renewal will be eligible for transitional participation in the program. Transitional

participation will terminate when the individual's income exceeds 225% of the federal poverty level;

(15) Requires any moneys remaining in the health care account to be used to reduce the participant's payments for the subsequent program period if the individual renews his or her participation. The division must refund any amount remaining in the health care account, less any outstanding individual obligations under the program, to a participant who is no longer eligible, has not renewed participation, or is terminated from the program;

(16) Specifies how health insurance coverage will be obtained for approved program participants;

(17) Prohibits the deductible for any qualified plan under the program from exceeding $2,500;

(18) Specifies that any licensed insurance agent or broker who sells a health insurance policy offered under the MHIP to an individual eligible for the program will receive a commission in an amount set by the Department of Social Services; and

(19) Requires the department, in consultation and coordination with the Department of Insurance, Financial Institutions, and Professional Registration and the MHIP board of directors, to ensure that eligible participants are able to obtain health insurance coverage through licensed insurance agents and brokers.

Certain provisions regarding the MHIP become effective January 1, 2009.

The substitute contains an emergency clause.

FISCAL NOTE: Estimated Cost on General Revenue Fund of Unknown but Greater than $49,017,646 in FY 2009, Unknown but Greater than $52,675,915 in FY 2010, and Unknown but Greater than $55,885,849 in FY 2011. Estimated Effect on Other State Funds of an income of Unknown to a cost of Unknown but Greater than $12,293,791 in FY 2009, an income of Unknown to a cost of Unknown but Greater than $60,289,673 in FY 2010, and an income of Unknown to a cost of Unknown but Greater than $106,108,982 in FY 2011.

PROPONENTS: Supporters of House Bill 2413 and House Bill 2398 say that the bills improve portability of health insurance, eliminate the barrier of earning more money and losing health care coverage through the transitional benefit provision, and provide coverage to low-income working individuals.

Supporters of House Bill 2355 say that it offers commonsense reform to the Certificate of Need Program, changing the

membership of the committee is a good reform, and the program is antiquated.

Supporters of House Bill 2394 say that the effect of suboptimal care is a large problem, and the bill will help health care consumers. Consumers can realize a savings in reduced premiums after time. The bill will also help consumers see the cost of health care and can change behavior to seek lower cost services.

Testifying for HB 2413 and HB 2398 were Representatives Ervin and Schaaf; Missouri Association of Homes for the Aging; United Healthcare; Missouri Catholic Conference; and Missouri Hospital Association.

Testifying for HB 2355 were Representative Flook; Missouri State Medical Association; and Missouri Association of Osteopathic Physicians and Surgeons.

Testifying for HB 2394 were Representative Ervin; United Healthcare; Blue Cross Blue Shield of Kansas City; St. Louis Area Business Health Coalition; Anthem Blue Cross Blue Shield; Ford Motor Company; and Missouri Hospital Association.

OPPONENTS: Those who oppose House Bill 2413 and House Bill 2398 say that changing the membership of the Health Facilities Review Committee can change the policy established by the committee, the fiscal impact on the state will be negative rather than positive as the program currently operates, and the process is shifted from consensus to adversarial.

Those who oppose House Bill 2355 say that the burden of proof should fall on both parties involved in the certificate of need process, and the bill appears to pit provider against provider when the Health Facilities Review Committee is intended to represent the consumer.

Those who oppose House Bill 2394 say that health care providers contract with many insurers and they don't always know which insurer will pay for the service, data information required by the physician and each insurer will require different data, and there are concerns about what will happen when a patient doesn't follow a doctor's orders and the doctor is penalized.

Testifying against HB 2413 and HB 2398 were Missouri Health Care Association.

Testifying against HB 2355 were Missouri Hospital Association; St. Louis Area Business Health Coalition; Ford Motor Company; Associated Industries of Missouri; Missouri Health Facilities Review Committee, Department of Health and Senior Services;

Missouri Health Care Association; and Hospital Corporation of America.

Testifying against HB 2394 were Missouri State Medical Association; Missouri Academy of Family Physicians; and Missouri State Chiropractors Association.

OTHERS: Others testifying on House Bill 2355 say that evidence should demonstrate that no need exists before a group is denied a certificate of need.

Others testifying on House Bill 2394 say that there might be problems with collecting quality data and new doctors could have problems with quality data.

Testifying on HB 2355 was Missouri Association of Homes for the Aging.

Testifying on HB 2394 was A.J. Delaney, MD.