HCS SS SCS SB 306 -- HEALTH CARE

SPONSOR: Dempsey (Ervin)

COMMITTEE ACTION: Voted "do pass" by the Special Committee on Health Insurance by a vote of 9 to 5.

This substitute changes the laws regarding health care.

INCOME TAX DEDUCTION FOR HEALTH INSURANCE PREMIUMS (Section 143.111, RSMo)

The substitute removes the deduction for a self-employed, Missouri resident's individual health insurance premiums from his or her adjusted gross income when computing his or her Missouri taxable income.

MISSOURI PATIENT PRIVACY ACT (Section 191.015)

The Missouri Patient Privacy Act is established which prohibits the disclosure of patient-specific health information to any employer, public or private payer, or employee or agent of a state department or agency without the written consent of the patient and health care provider. Health information may be disclosed to a health insurer, employer, state employee or agent of the Missouri Consolidated Health Care Plan, the Department of Health and Senior Services, or the MO HealthNet Division within the Department of Social Services in connection with the employee's official duties including oversight of state health problems, tracking infectious diseases, administering state wellness initiatives and programs, and researching state medical trends. The substitute does not prohibit disclosure of personal health information consistent with federal law and does not require health care providers to obscure or remove the information when disclosing it.

EVAN de MELLO REIMBURSEMENT PROGRAM (Section 191.940)

The Evan de Mello Reimbursement Program is established within the departments of Health and Senior Services and Mental Health to provide financial assistance for the cost of transportation and ancillary services associated with the medical treatment of an eligible child. The program is the payer of last resort after all other available sources have been exhausted, and reimbursement is subject to appropriations. To be eligible for assistance under the program, a child must be suffering from a condition or impairment that results in severe physical illness or impairments, in need of transportation or ancillary services due to his or her condition, certified by a physician of the child's choice as a child who will likely benefit from medical

services, and required to travel at least 100 miles for medical services which the child's parents or guardian are unable to pay the travel expenses.

The departments must establish rules which include an application and review process, a cap on benefits that cannot be less than $5,000 per recipient, and a household income eligibility limit which cannot exceed 350% of the federal poverty level.

TRANSPARENCY OF HEALTH CARE INFORMATION (Sections 191.1005, 191.1008, and 191.1010)

Insurers with programs that publicly assess and compare the quality and cost efficiency of health care providers must conform to specified criteria for the transparency of health care information.

Any person who sells or distributes comparative health care quality and cost-efficiency data for public disclosure must identify the measuring technique used to validate and analyze the data, except for articles or research studies published in peer-reviewed academic journals that do not receive funding from a health care insurer or state or local government. Individuals violating this provision will be investigated by the Department of Health and Senior Services and may be subject to a penalty of up to $1,000. Health insurers violating this provision will be investigated by the Department of Insurance, Financial Institutions and Professional Registration and subject to the department's enforcement powers of the state's insurance laws.

PREMATURE INFANTS (Sections 191.1127 and 191.1130)

The substitute requires the MO HealthNet Program and the Health Care for Uninsured Children Program, in consultation with statewide organizations, to examine and improve hospital discharge and follow-up care procedures for premature infants born earlier than 37 weeks gestational age, report rehospitalizations within six months, and use guidance from the Centers for Medicare and Medicaid Services' Neonatal Outcomes Improvement Project to improve outcomes, reduce costs, and establish ongoing quality improvement for newborns. By December 31, 2009, the Department of Health and Senior Services must prepare written educational publications with information about possible complications, proper care, and support associated with premature infants and must distribute the materials to providers, hospitals, health departments, and medical organizations.

INTERNET WEB-BASED PRIMARY CARE ACCESS PILOT PROJECT (Section 191.1200)

The General Assembly is required to appropriate $400,000 from the Health Care Technology Fund to the Department of Social Services to award 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 the nonemergency use of the hospital emergency room as consistent with federal law and regulations.

TELEHEALTH (Sections 191.1250, 191.1256, 191.1259, 191.1265, and 191.1271)

The substitute specifies that the delivery of health care through telehealth is recognized and encouraged as a safe, practical, and necessary practice in the state. By January 1, 2010, the Department of Health and Senior Services must establish quality control rules and regulations to be used in removing and improving the services of telehealth practitioners.

REPORTING SERIOUS HEALTH CARE INCIDENTS (Sections 197.553, 197.556, and 197.559)

Beginning January 1, 2010, hospitals must report all serious health care incidents resulting in serious adverse events to a federally designated patient safety organization no later than one business day following the discovery of the incident. The report must describe the immediate actions taken to minimize patient risk and the prevention measures carried out. The hospital will have 45 days after the incident was discovered to submit a root cause analysis report and prevention plan to the organization, with or without the technical assistance of the organization. If the organization finds any of the reports provided by the hospital to be insufficient, the hospital will have two attempts to make corrections. The Department of Health and Senior Services will assist hospitals with three or more insufficient reports and accept reports from a hospital that does not submit serious adverse events to an organization if it is permissible under the federal Patient Safety and Quality Improvement Act of 2005. The organization assessing reported incidents must provide the hospital with a report to prevent future incidents. These provisions must not be construed to restrict the availability of information from original sources or limit the disclosure or use of information from original sources.

PATIENT SAFETY ORGANIZATIONS (Sections 197.562 - 197.586)

If permitted by the federal Patient Safety and Quality Improvement Act of 2005, the Department of Health and Senior Services will publish an annual report by April 30 on reportable

incidents that indicates the number of reportable events by the current National Quality Forum categories by rate per patient encounter by region and by category of reportable incident and by facility. An individual is prohibited from disclosing the actions, decisions, proceedings, discussions, or deliberations occurring at a patient safety organization except for specified purposes. The proceedings and records of an organization cannot be used as evidence in a civil action against a health care provider arising out of matters that are subject to consideration by an organization. Patient safety work product is privileged and confidential under the federal act. Any reference to or offer into evidence of patient safety work product during any proceeding will constitute grounds for a mistrial or a termination of the proceeding and reversible error on appeal from any judgment or order in favor of any party who discloses it into evidence. An organization can disclose nonidentifiable information regarding the number and types of patient safety events that have occurred and must publish educational and evidence-based information to improve patient care. The confidentiality of patient safety work product must not be impaired or adversely affected by its submission to an organization. The exchange and disclosure of patient safety work product by an organization is not a waiver of confidentiality of the health care provider who submitted the data. Any provider furnishing services to an organization will not be liable for civil damages for duties performed on behalf of the organization unless done with actual malice, fraudulent intent, or bad faith. Beginning January 1, 2010, a hospital that reports a reportable incident cannot charge for or bill any entity for all services related to the incident. If a third-party payor denies a claim because of lack of coverage for services that resulted from a reportable incident of a serious adverse event, the health care provider or facility involved cannot bill the patient for the services.

HOSPITAL DISTRICT SALES TAXES (Section 205.202)

Hospital districts in certain counties, including Ripley County, upon voter approval, are authorized to abolish the hospital district property tax and impose a retail sales tax of up to 1% for funding the hospital district. Moneys collected from the tax will be deposited into the newly created Hospital District Sales Tax Fund with 1% retained and deposited into the General Revenue Fund by the Director of the Department of Revenue for the cost of collection.

MO HEALTHNET PAYMENTS (Sections 208.152 and 208.215)

MO HealthNet Program payments for services provided by hospitals, physician offices, nursing homes, and other health care providers

will only be made if the service provider has a contractual agreement with the carrier that has a health care transparency agreement as of January 1, 2011.

Any third-party administrator, administrative service organization, health benefit plan, or pharmacy benefits manager must process and pay all properly submitted MO HealthNet Program medical assistance subrogation claims for a period of three years from the date the services were rendered, regardless of any other timely filing requirement. The entity cannot deny claims based on the type or format of the claim form, failure to present proper documentation of coverage at the point of sale, or failure to obtain prior authorization. The MO HealthNet Division within the Department of Health and Senior Services must enforce its rights within six years of the state's timely submission of a claim. MO HealthNet vendors who contract for third-party liability services must provide the division with coverage and eligibility data needed to identify if a MO HealtNet participant has coverage from a liable third party before a claim can be submitted to the state.

CO-PAYMENTS FOR PRESCRIPTION DRUGS (Section 354.535)

When the usual and customary retail price of a prescription drug is less than the co-payment applied by a health maintenance organization or health insurer, the enrollee will only be required to pay the usual and customary retail price of the prescription drug and there will be no further charge to the enrollee or plan sponsor for the prescription.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)(Section 354.536)

The substitute requires proof that a dependent child is incapable of maintaining employment due to a mental or physical handicap and is dependent upon the policy holder for support and maintenance to be submitted to the insured's HMO within 31 days after the child has attained the age when the child's coverage is to be terminated instead of the current at least 31 days.

STANDARDIZED INSURANCE APPLICATIONS (Section 374.184)

The Director of the Department of Insurance, Financial Institutions and Professional Registration is required to establish by rule uniform insurance application forms to be used by all insurers for group health insurance policies.

REIMBURSEMENT CLAIMS (Section 376.384)

By January 1, 2010, a health carrier responding to an electronic patient financial responsibility inquiry must respond with the

eligibility or benefit information codes for co-payment, co-insurance, deductible, out-of-pocket maximum, remaining deductible amount, and other cost containment elements.

HEALTH INSURANCE CO-PAYMENTS AND CO-INSURANCE (Section 376.391)

Health insurers are prohibited from imposing any co-payment or co-insurance, or combination thereof, that exceeds 50% of the total cost of providing the health care service to an enrollee.

DIAGNOSTIC IMAGING SERVICES (Section 376.394)

The substitute prohibits a health carrier or health benefit plan from denying reimbursement for diagnostic imaging services based solely on a licensed physician's specialty or professional board certification.

CONVERTED HEALTH INSURANCE POLICIES (Sections 376.397 and 376.401)

When a group health insurance policy is terminated, the group health insurer cannot refuse to convert a health insurance policy or coverage of an insured person if he or she is eligible for Medicare or any other state or federal benefits. The Medicare or any other state or federal benefit cannot result in a reduction or termination of coverage of any person for a converted group health insurance policy.

GROUP HEALTH INSURANCE POLICIES (Sections 376.421, 376.424, and 376.426)

The substitute repeals the provision which allows a group health insurer to exclude or limit coverage on any person for policies insuring fewer than 10 employees when there is evidence of unsatisfactory individual insurability and also repeals a similar provision for group health insurance policies with more than 10 employees when an application is not made within 31 days after the date of eligibility or the person voluntarily terminates coverage or fails to enroll during the open enrollment period.

Currently, group health insurance policies must contain a provision that specifies any exclusions and limitations to the policy in regard to a disease or physical condition that an individual was treated for during the 12 months prior to the enrollment date of an individual's policy. The substitute limits the exclusions and limitations to the prior six months before an individual becomes covered under the policy. Exclusions and limitations cannot apply to a loss or disability that occurred after the enrollment date or during the 18-month period thereafter in the case of a late enrollee. The substitute

requires proof that a dependent child is incapable of maintaining employment due to a mental or physical handicap and is dependent upon the policy holder for support and maintenance to be submitted to the health insurer within 31 days after the dependent child has attained the age when coverage is to be terminated in order to sustain coverage instead of the current at least 31 days.

INSURANCE COVERAGE AFTER TERMINATION OF EMPLOYMENT (Sections 376.428, 376.437, 376.439, and 376.443)

The substitute requires group policies by a health carrier or health benefit plan to comply with the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provisions regarding the continuation of group health insurance coverage to an individual who has terminated employment or membership.

Every group policy, contract, or health benefit plan issued, delivered, or renewed on or after January 1, 2010, must contain a provision that allows an employee or group member, whose continuation coverage under the federal COBRA law or the state's continuation law has expired to continue coverage under the group policy or health benefit plan if the employee or group member was 55 years of age or older when the coverage expired. The right to extended continuation coverage will terminate upon the earliest of the following:

(a) The date the employee or group member fails to pay premiums or required premium contributions;

(b) The date that the group policy or plan is terminated to all group members except if a different policy or plan is made available;

(c) The date on which the employee or group member becomes insured under another group policy;

(d) The date on which the employee or group member becomes eligible for coverage under Medicare; or

(e) The date on which the employee or group member attains 65 years of age.

The substitute requires all group health insurance policies delivered, issued, or renewed on or after January 1, 2010, to individuals eligible for continuation coverage under state law to have their coverage be pooled experience to across all fully insured group business in Missouri. The experience of all persons covered by a continuation of coverage provision must be pooled and spread over all fully insured premiums in Missouri on

an equal percentage basis.

The substitute requires health carriers who provide group insurance policies to persons who are exercising their continuation of coverage rights under COBRA or the state to offer them the option of continuation of coverage through a health savings account eligible high deductible health plan. The premium for the high deductible plan must be consistent with the underlying group plan of coverage rated relative to the standard or manual rates for the benefits provided.

MISSOURI HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (Sections 376.450.1 and 376.450.6)

The State Children's Health Insurance Program (SCHIP) coverage is added to the list of credible coverages for individuals. The definition for "waiting period" as it relates to the Missouri Health Insurance Portability and Accountability Act is revised to be a time period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll in a group health plan becomes effective. Any time period before late or special enrollment is not considered a waiting period for late or special enrollees. A waiting period begins on the date an individual submits an application for coverage and ends when the application for coverage is approved, denied, or lapses. Health issuers offering group coverage will be required to provide a special enrollment period for a dependent in the case of a placement for adoption.

EMPLOYER REQUIREMENTS (Section 376.453)

If an employer provides health insurance to an employee and the employee pays any portion of the cost of the premium, the employer must also provide a premium-only cafeteria plan or a health reimbursement arrangement.

INDIVIDUAL HEALTH INSURANCE POLICIES (Section 376.776)

The substitute requires proof that a dependent child is incapable of maintaining employment due to a mental or physical handicap and is dependent upon the policy holder for support and maintenance to be submitted to the health insurer within 31 days after the dependent child has attained the age when coverage is to be terminated in order to sustain coverage instead of the current at least 31 days.

MISSOURI HEALTH INSURANCE POOL (HIGH RISK POOL) (Sections 376.966, 376.985, 376.986, and 376.987)

The substitute specifies that a person's eligibility for COBRA or

continuation rights under state law cannot render him or her ineligible for coverage under the high risk pool.

All health insurers are required to notify an insured person when he or she has exhausted 85% of his or her total lifetime health insurance benefits and of 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.

By January 1, 2010, the pool must offer at least two health benefit plans for an individual for coverage under the pool and the newly established Show-Me Health Coverage Plan. Subject to funding, the pool's board can establish a premium subsidy program for eligible low-income individuals.

An individual who has exceeded his or her total lifetime health insurance benefits from his or her insurer is eligible for the pool which has a $2 million lifetime benefit. An individual who is eligible and has an income of less than 350% of the federal poverty level will receive a 50% discount off the pool's premiums.

The pool is required to offer high deductible health plans in conjunction with a health savings account on a guaranteed-issue basis.

LIMITED MANDATE HEALTH INSURANCE POLICIES (Section 376.995)

The current marketing restriction placed upon the sale of limited mandate health insurance policies is repealed which limits the sale of these policies to individuals who do not have health insurance or employers who certify in writing to the insurer that they will terminate their current coverage because of the current costs.

MANDATED COVERAGE FOR PROSTHETIC DEVICES AND SERVICES (Section 376.1232)

Every health carrier or health benefit plan delivered, issued, continued, or renewed on or after January 1, 2010, must offer coverage for prosthetic devices and services.

RIGHT TO RECEIVE DOCUMENTS (Section 376.1450)

Currently, a health insurance plan enrollee can opt out from receiving documents from his or her managed care entity in print form and access the documents electronically. The substitute specifies that the enrollee must, upon request, receive the documents in the printed form.

HEALTH REIMBURSEMENT ARRANGEMENT ONLY PLANS (Section 376.1600)

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 individual health insurance coverage. The substitute specifies that "health reimbursement arrangement" means an employee benefit plan provided by an employer which establish an account funded solely by the employer to reimburse the employee for qualified medical expenses incurred by the employee or his or her family. An employee is allowed to carry forward any unused funds at the end of the coverage period to subsequent coverage periods.

HEALTH SAVINGS ACCOUNT HEALTH BENEFIT PLANS (Section 376.1603)

The Director of the Department of Insurance, Financial Institutions and Professional Registration must develop flexible guidelines for coverage and approval of health savings account eligible high deductible health plans for use with health savings accounts which comply with federal requirements. The department director is authorized to promote and encourage the marketing of these plans in the state and must conduct a national study of health savings account eligible high deductible plans available in other states and determine if and how these plans serve the uninsured and if they should be made available to Missourians. The department director must develop a fast track or automatic approval process for these plans that have already been approved in Missouri or other states.

INSURANCE PRODUCTS BARRIERS STUDY (Section 376.1618)

The Director of the Department of Insurance, Financial Institutions and Professional Registration must study and recommend to the General Assembly on needed changes to remove any unnecessary application and marketing barriers as well as state statutory and regulatory requirements that limit the entry of new health insurance products into the Missouri insurance market. The department director must examine proposals adopted in other states that streamline the regulatory environments to make it easier for health insurance companies to market new and existing products. The report of the department director's findings and recommendations must be submitted to the General Assembly by January 1, 2010.

SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT (Sections 379.930, 379.940, and 379.952)

The definition of "dependent" is changed in the Small Employer Health Insurance Availability Act to be consistent with the

definition in the statutes regarding health maintenance organizations and individual and group policies by revising it to be a person who is a spouse, an unmarried child who resides in Missouri and is younger than 25 years of age and is not covered by any group or individual health benefit plan or entitled to federal Social Security assistance benefits, or an unmarried child of any age who is disabled and dependent upon his or her parent.

A small employer insurance carrier must reasonably compensate an agent or broker for the sale of any small employer health benefit plan, and a small employer carrier must maintain and issue all health benefit plans it actively markets to small employers in the state.

Currently, a small employer insurance carrier will not be in violation of any unfair trade practice if the small employer charges a lesser premium or deductible for employees who do not use tobacco products. The substitute revises the definition of "unfair trade practice" by using the provisions that apply to all insurance carriers in Missouri instead of only to health and accident insurance companies.

SHOW-ME HEALTH COVERAGE PLAN (Sections 1 - 10)

Subject to appropriations, the substitute establishes the Show-Me Health Coverage Plan in the Department of Social Services to provide health care coverage through the Missouri Health Insurance Pool to low-income adult Missourians. In order to operate the program, the department must apply to the United States Department of Health and Human Services for approval of a Section 115 demonstration waiver to develop and implement the plan, provided that any reduction of disproportionate share of hospital funds applied to the cost of the plan as required by the waiver will not be disproportionate to the impact on low-income uninsured individuals. The plan will be void if there are no federal funds appropriated to the state or if no disproportionate share hospital funds are applied to the program. The department must get approval of the Joint Committee on MO HealthNet before applying for the federal waiver. The Department of Insurance, Financial Institutions and Professional Registration and the MO HealthNet Division will provide oversight of the marketing practices of the plan, and the Department of Social Services and the Missouri Health Insurance Pool must promote the plan and provide information to potential eligible individuals. The plan is not an entitlement program, and the maximum enrollment is dependent on appropriated funding from the General Assembly and may be phased in incrementally. The substitute specifies the eligibility requirements for participants in the plan.

MO HEALTHNET FOR KIDS PROGRAM (Section 11)

If the income of a taxpayer who reports the absence of health care coverage for a dependent child does not exceed 150% of the federal poverty level, the Department of Revenue must send a notice, which is to be developed by the Department of Social Services, to the taxpayer indicating that the child may be eligible for the MO HealthNet for Kids Program and provide information about enrollment in the program.

MO HEALTHNET PROGRAM REIMBURSEMENTS (Section 12)

Subject to appropriations, the Department of Social Services must establish a rate for the reimbursement of physicians, optometrists, podiatrists, and psychologists for services rendered to patients under the MO HealthNet Program which is equal to the reimbursement for the same or similar services rendered.

The provisions of the substitute regarding the Show-Me Health Coverage Plan will expire six years from the effective date.

The substitute contains an emergency clause for the provisions regarding group policies to comply with the federal COBRA provisions and the provisions regarding certain hospital districts lowering their property tax levies.

FISCAL NOTE: Estimated Cost on General Revenue Fund of Unknown but Greater than $22,186,624 in FY 2010, Unknown but Greater than $38,687,173 in FY 2011, and Unknown but Greater than $55,000,796 in FY 2012. Estimated Cost on Other State Funds of Unknown but Greater than $7,518,576 in FY 2010, Unknown but Greater than $11,775,469 in FY 2011, and Unknown but Greater than $15,407,217 in FY 2012.

PROPONENTS: Supporters say that the bill will help fund health care for low-income individuals who cannot afford insurance by utilizing disproportionate share hospital funds and the federal reimbursement allowance program to provide coverage for these uninsured individuals instead of using those funds for uncompensated care at hospitals under the newly established Show-Me Health Care Coverage Plan. A federal waiver is required in order to cover a person over 100% of the federal poverty level; however, a state plan amendment will cover those under 100%. The health savings account will be handled by the insurance carrier. The plan it is not mandatory for eligible individuals. The provisions specified in the plan focus on wellness and prevention and will be delivered through current Medicaid providers.

Testifying for the bill were Senator Dempsey; and Missouri

Hospital Association.

OPPONENTS: There was no opposition voiced to the committee.

OTHERS: Others testifying on the bill say that the Show-Me Health Coverage Plan does not include dental or vision services. The total plan is subject to appropriations and requires approval. Uncompensated care payments will be redirected to provide coverage for uninsured persons.

Testifying on the bill was Department of Social Services.