House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Committee Substitute for House Bill No. 986, Page 8, Section 208.151, Line 170, by deleting all of said line and inserting in lieu thereof the following:

"2. Beginning July 1, 2014, eligibility for MO HealthNet benefits shall be amended as follows:

(1) Persons eligible under subdivisions (3) and (25) of subsection 1 of this section shall no longer be eligible for MO HealthNet benefits as provided in this section, except for those persons eligible under subdivision (25) who do not have access to employer-sponsored health insurance coverage or subsidized insurance coverage through an exchange at any point after diagnosis, whose income is above one hundred percent of the federal poverty level;

(2) Pregnant women who are eligible under subdivision (12) of subsection 1 of this section, with income that does not exceed one hundred eighty-five percent of the federal poverty level shall be eligible for MO HealthNet benefits. Pregnant women with income between one hundred thirty-three and one hundred eighty-five percent of the federal poverty level may, at the discretion of the department, receive MO HealthNet benefits in the form of a premium subsidy as established by rule of the department in order for them to enroll in a plan offered by a health care exchange, whether federally facilitated, state based, or operated on a partnership basis. The department may direct the pregnant women to choose an exchange plan and the department may provide a premium subsidy equal to the amount of the percentage of income required for premium payments or coinsurance to the pregnant women by federal rule. The department may encourage and incentivize eligible pregnant women to receive MO HealthNet benefits through an exchange plan;

(3) Beginning October 1, 2019, infants under one year of age who are eligible under subdivision (12) of subsection 1 of this section and whose family income does not exceed one hundred eighty-five percent of the federal poverty level as established and amended by the federal Department of Health and Human Services or its successor agency shall be eligible for MO HealthNet benefits. An infant under one year of age born to a woman who was covered under subdivision (2) of this subsection with family income between one hundred thirty-three and one hundred eighty-five percent of the federal poverty level shall only be eligible if, in addition to the other requirements, his or her parents do not have access to health insurance coverage for the child through a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis, and the parents are not eligible for a premium subsidy for the child or family through such exchange because the parents have been determined to have access to affordable health insurance as defined by the exchange;

(4) The changes in eligibility under subdivisions (1) to (3) of this subsection shall not take place unless and until:

(a) There are health insurance premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership

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basis. The director of the department of revenue shall certify to the director of the department that health insurance premium tax credits are available, and the director of the department shall notify the revisor of statutes;

(b) Eligibility of persons set out in subsection 3 of section 208.995 has been approved by the federal Department of Health and Human Services, has been implemented by the department, and notice of implementation has been provided to the revisor of statutes; and

(c) The federal Department of Health and Human Services grants any necessary waivers and state plan amendments to implement this subsection, federal funding is received for the premium subsidies to be paid, and notice has been provided to the revisor of statutes.

3. Rules and regulations to implement this section shall be promulgated in accordance"; and

Further amend send bill and section, Pages 8 to 9, Lines 179 to 221, by renumbering all of the following subsections accordingly; and

Further amend said bill and section, Page 9, Line 221, by inserting after all of said line the following:

"8. The department shall notify any potential exchange-eligible participant who may be eligible for services due to spenddown that the participant may qualify for more cost-effective private insurance and premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis and the benefits that would be potentially covered under such insurance.

208.186. 1. Any person participating in the MO HealthNet program who has pled guilty to or been found guilty of a crime involving alcohol or a controlled substance or any crime in which alcohol or substance abuse was, in the opinion of the court, a contributing factor to the person's commission of the crime shall be required to obtain an assessment by a treatment provider approved by the department of mental health to determine the need for services. Recommendations of the treatment provider may be used by the court in sentencing.

2. Any person participating in the MO HealthNet program who is a parent of a child subject to proceedings in juvenile court under subsection 1 or 2 of section 211.031, whose misuse of controlled substances or alcohol is found to be a significant, contributing factor to the reason the child was adjudicated, shall be required to obtain an assessment by a treatment provider approved by the department of mental health to determine the need for services. Recommendations of the treatment provider shall be included in the child's permanency plan. The court may order the parent or guardian to successfully complete treatment before the child is reunified with the parent or guardian.

3. The MO HealthNet division shall certify a MO HealthNet participant's enrollment in MO HealthNet if requested by the court under this section. A letter signed by the director of the MO HealthNet division or his or her designee or the family support division certifying that the individual is a participant in the MO HealthNet program shall be prima facie evidence of such participation and shall be admissible into evidence without further foundation for that purpose. The letter may specify additional information such as anticipated dates of coverage as may be deemed necessary by the department.

208.631. 1. Notwithstanding any other provision of law to the contrary, the MO HealthNet division shall establish a program to pay for health care for uninsured children. Coverage pursuant to sections 208.631 to 208.659 is subject to appropriation. The provisions of sections 208.631 to 208.569, health care for uninsured children, shall be void and of no effect if there are no funds of the United States appropriated by Congress to be provided to the state on the basis of a state plan approved by the federal government under the federal Social Security Act. If funds are appropriated

by the United States Congress, the department of social services is authorized to manage the state children's health insurance program (SCHIP) allotment in order to ensure that the state receives maximum federal financial participation. Children in households with incomes up to one hundred fifty percent of the federal poverty level may meet all Title XIX program guidelines as required by the Centers for Medicare and Medicaid Services. Children in households with incomes of one hundred fifty percent to three hundred percent of the federal poverty level shall continue to be eligible as they were and receive services as they did on June 30, 2007, unless changed by the Missouri general assembly.

2. For the purposes of sections 208.631 to 208.659, "children" are persons up to nineteen years of age. "Uninsured children" are persons up to nineteen years of age who are emancipated and do not have access to affordable employer-subsidized health care insurance or other health care coverage or persons whose parent or guardian have not had access to affordable employer-subsidized health care insurance or other health care coverage for their children for six months prior to application, are residents of the state of Missouri, and have parents or guardians who meet the requirements in section 208.636. A child who is eligible for MO HealthNet benefits as authorized in section 208.151 is not uninsured for the purposes of sections 208.631 to 208.659.

3. Beginning October 1, 2019, a child eligible under sections 208.631 to 208.658 shall only remain eligible if, in addition to the other requirements, his or her parents do not have access to health insurance coverage for the child through their employment or through a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis because the parents are not eligible for a premium subsidy for the child or family through such exchange. This subsection shall not go into effect unless and until, for a six-month period preceding the additional requirements, there are health insurance premium tax credits available for children and family coverage under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis, which have been in place for a six-month period.

4. The department shall inform participants six months prior to coverage being discontinued under subsection 3 of this section as to the possibility of insurance coverage through the purchase of a subsidized health insurance plan available through a health care exchange.

208.659. 1. The MO HealthNet division shall revise the eligibility requirements for the uninsured women's health program, as established in 13 CSR Section 70-4.090, to include women who are at least eighteen years of age and with a net family income of at or below one hundred eighty-five percent of the federal poverty level. In order to be eligible for such program, the applicant shall not have assets in excess of two hundred and fifty thousand dollars, nor shall the applicant have access to employer-sponsored health insurance. Such change in eligibility requirements shall not result in any change in services provided under the program.

2. Beginning July 1, 2014, the provisions of this section shall no longer be in effect. Such change in eligibility shall not take place unless and until:

(1) For a six-month period preceding the discontinuance of benefits under this subsection there are health insurance premium tax credits available for children and family coverage under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis, which have been in place for a six-month period, and notice has been provided to the revisor of statutes; and

(2) Eligibility of persons set out in subsection 3 of section 208.995 has received any necessary approvals from the federal Department of Health and Human Services, has been implemented by the department, and notice has been provided to the revisor of statutes.

3. The department shall inform participants six months prior to coverage being discontinued under subsection 2 of this section as to the possibility of insurance coverage through the purchase of a subsidized health insurance plan available through a health care exchange.

208.661. 1. The department shall develop incentive programs, submit state plan amendments and apply for necessary waivers to permit rural health clinics, federally-qualified health centers, or other primary care practices to co-locate on the property of public elementary and secondary schools with fifty percent or more students who are eligible for free or reduced price lunch.

2. No school-based health care clinic established under this section shall perform or refer for abortion services, or provide or refer for contraceptive drugs or devices.

3. The consent of a parent or legal guardian shall be required before a minor may receive health care services under this section.

4. The provisions of this section shall be null and void unless and until any waivers necessary to the implementation of subsections 2 and 3 of this section are granted by the federal government.

208.662. 1. There is hereby established within the department of social services the "Show-Me Healthy Babies Program" as a separate children's health insurance program (CHIP) for any low-income, unborn child, neither of whose parents have access to affordable health insurance coverage for the unborn child through his or her employment or through a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis. The program shall be established under the authority of Title XXI of the federal Social Security Act, the State Children's Health Insurance Program, as amended, and 42 CFR 457.1.

2. For an unborn child to be enrolled in the show-me healthy babies program, his or her mother shall not be eligible for coverage under Title XIX of the federal Social Security Act, the Medicaid program, as it is administered by the state, and shall not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child including any health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis.

3. Coverage for an unborn child enrolled in the show-me healthy babies program shall include all prenatal care and pregnancy-related services that benefit the health of the unborn child and that promote healthy labor, delivery, and birth, as determined by regulations of the department. Coverage shall not include services that are solely for the benefit of the pregnant mother, that are unrelated to maintaining or promoting a healthy pregnancy, and that provide no benefit to the unborn child.

4. There shall be no waiting period before an unborn child may be enrolled in the show-me healthy babies program. In accordance with the definition of child in 42 CFR 457.10, coverage shall include the period from conception to birth. The department shall develop a presumptive eligibility procedure for enrolling an unborn child.

5. Coverage for the child shall continue for up to one year after birth, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations.

6. Pregnancy-related and postpartum coverage for the mother shall begin on the day the pregnancy ends and extend through the last day of the month that includes the sixtieth day after the pregnancy ends, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations. Coverage for the mother shall be limited to pregnancy-related and postpartum care.

7. Nothing in this section shall be construed to prohibit an unborn child from being enrolled in the show-me healthy babies program at the same time his or her mother is enrolled in MO HealthNet, the children's health insurance program (CHIP), Medicare, or other governmental or

government-subsidized health care program. The department shall ensure that there is no duplication of payments for services for an unborn child enrolled in the show-me healthy babies program that are payable under a governmental or nongovernmental health care program for services to an eligible pregnant woman.

8. The department may provide coverage for an unborn child enrolled in the show-me healthy babies program through:

(1) Direct coverage whereby the state pays health care providers directly or by contracting with a managed care organization or with a group or individual health insurance provider;

(2) A premium assistance program whereby the state assists in payment of the premiums, co-payments, coinsurance, or deductibles for a person who is eligible for health coverage through an employer, former employer, labor union, credit union, church, spouse, other organizations, other individuals, or through an individual health insurance policy that includes coverage for the unborn child, when such person needs assistance in paying such premiums, co-payments, coinsurance, or deductibles;

(3) A combination of direct coverage, such as when the unborn child is first enrolled, and premium assistance, such as after the child is born; or

(4) Any other similar arrangement whereby there:

(a) Are lower program costs without sacrificing health care coverage for the unborn child or the child up to one year after birth;

(b) Are greater covered services for the unborn child or the child up to one year after birth;

(c) Is a similar cost for coverage of the participant and also will provide coverage for siblings or other family members; or

(d) Will be an ability for the child to transition more easily to nongovernment or less government-subsidized group or individual health insurance coverage after the child is no longer enrolled in the show-me healthy babies program.

9. The department shall provide information about the show-me healthy babies program to maternity homes as defined in section 135.600, pregnancy resource centers as defined in section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. The department shall consider allowing such agencies and programs to assist in the enrollment of unborn children in the program and in making determinations about presumptive eligibility.

10. Within sixty days after the effective date of this section, the department shall submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the show-me healthy babies program.

11. At least annually, the department shall prepare and submit a report to the governor, the speaker of the house of representatives, and the president pro tem of the senate analyzing the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, health care providers, employers, other public and private entities, and persons by enrolling unborn children in the show-me healthy babies program. The analysis of cost savings and benefits, if any, shall include but not be limited to:

(1) The higher federal matching rate for having an unborn child enrolled in the show-me healthy babies program versus the lower federal matching rate for a pregnant woman being enrolled in MO HealthNet or other federal programs;

(2) The efficacy in providing services through managed care organizations, group or individual health insurance providers or premium assistance, or through other nontraditional arrangements of providing health care;

(3) The change in the proportion of unborn children who receive care in the first trimester of pregnancy due to a lack of waiting periods, presumptive eligibility, or removal of other barriers, and

the attendant decrease in health problems and other problems for unborn children and women throughout pregnancy; at labor, delivery, and birth; and during infancy and childhood;

(4) The change in healthy behaviors by pregnant women, such as the cessation of the use of tobacco, alcohol, illicit drugs, or other harmful practices, and the attendant short-term and long-term decrease in birth defects; poor motor skills; vision, speech, and hearing problems; breathing and respiratory problems; feeding and digestive problems; and other physical, mental, educational, and behavioral problems; and

(5) The change in infant and maternal mortality, preterm births and low birth weight babies and the attendant decrease in short-term and long-term medical and other interventions.

12. The show-me healthy babies program shall not be deemed an entitlement program, but instead shall be subject to a federal allotment or other federal appropriations and matching state appropriations.

13. Nothing in this section shall be construed as obligating the state to continue the show-me healthy babies program if the allotment or payments from the federal government end or are not sufficient for the program to operate, or if the general assembly does not appropriate funds for the program.

14. Nothing in this section shall be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state."; and

Further amend said bill and page, Section 208.990, Line 1, by deleting all of said line and inserting in lieu thereof the following:

"208.990. 1. The provisions of sections 208.146, 208.151, 208.186, 208.631, 208.659, 208.661, 208.662, 208.990, 208.995, 208.997, 208.998, 208.999, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, 376.973, 1 and 2 shall be known and may be cited as the "Show-Me Transformation Act".

2. Notwithstanding any other provisions of law to the contrary, to be"; and

Further amend said bill and section, Page 10, Lines 14 to 33, by renumbering all of the following subsections accordingly; and

Further amend said bill and section, Page 11, Line 48, by inserting after all of said line the following:

"7. The MO HealthNet program shall not provide MO HealthNet coverage under subsection 3 of section 208.995 to a parent or other caretaker relative living with a dependent child unless the child is receiving benefits under the MO HealthNet program, the Children's Health Insurance Program (CHIP) under 42 CFR Chapter IV, Subchapter D, or otherwise is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

8. (1) The provisions of the show-me transformation act shall be null and void unless and until:

(a) There are health insurance premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a heath care exchange, whether federally facilitated, state based, or operated on a partnership basis;

(b) Eligibility of persons set out in subsection 3 of section 208.995 has been approved by the federal Department of Health and Human Services and has been implemented by the department;

(c) The federal Department of Health and Human Services grants the required waivers, state plan amendments, and enhanced federal funding rate for persons newly eligible under subsection 3 of section 208.995 whereby the federal government agrees to pay the percentages specified in Section 2001 of PL 111-148, as that section existed on March 23, 2010. The provisions of

subsections 3 to 8 of section 208.995 shall not be implemented unless such waivers and enhanced federal funding rates are granted by the federal government;

(2) If the federal funds at the disposal of the state shall at any time become less than ninety percent of the funds necessary or are not appropriated to pay the percentages specified in Section 2001 of Public Law 111-148, as that section existed on March 23, 2010, the provisions of this act shall be null and void. If the director is notified that federal funding will fall below ninety percent of the funds necessary, participants will be notified as soon as practicable that the benefits they receive will terminate on the date that federal funding falls below ninety percent;

(3) The provisions of subdivisions (1) and (2) of this subsection shall not apply to: the MO HealthNet transformation task force under section 2; subdivision (26) of subsection 1 of section 208.151; subsections 2, 3, 4, 5, and 6 of this section; and subdivision (2) of subsection 2 of section 208.995.

9. As MO HealthNet or other expenditures are reduced or savings achieved pursuant to the show-me transformation act, the portion of the state share of those expenditures that is funded by provider taxes described in 42 CFR 433.56 shall be credited or otherwise shall accrue to the depository account in which the proceeds of such a provider tax are deposited."; and

Further amend said bill, Page 12, Section 208.995, Lines 1 and 2, by deleting all of said lines and inserting in lieu thereof the following:

"208.995. 1. For purposes of sections 208.990 to 208.998, the following terms mean:

(1) "Caretaker relative", a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, which may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes, and who is one of the following:

(a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or

(b) The spouse of such parent or relative, even after the marriage is terminated by death or divorce;"; and

Further amend said bill, page, and section, Lines 3 to 15, by renumbering all of the following subdivisions accordingly; and

Further amend said bill, page, and section, Line 17, by deleting all of said line and inserting in lieu thereof the following:

"were in effect prior to the enactment of Public Law 111-148 and Public Law 111-152;

(7) "Medically frail", individuals with:

(a) Serious emotional disturbances;

(b) Disabling mental disorders;

(c) Substance use disorders or chronic medical conditions who are at high risk for significant medical and social costs;

(d) Serious and complex medical conditions, including children who are deemed medically complex;

(e) Physical or mental disabilities that significantly impair the person's ability to perform one or more activities of daily living; or

(f) An adjudicated level of care of twenty-one points or greater as determined by the screening process under 42 CFR 483.100 to 483.138, or deemed eligible for skilled nursing facility placement, but who are not currently residing in a nursing facility."; and

Further amend said bill and section, Page 13, Line 55, by deleting all of said line and inserting in lieu thereof the following:

"3. (1) Effective January 1, 2014, and subject to the receipt of appropriate waivers and approval of state plan amendments, individuals who meet the following qualifications shall be eligible for the alternative package of MO HealthNet benefits as set forth in subsection 4 of this section, subject to the other requirements of this section:

(a) Are nineteen years of age or older and under sixty-five years of age;

(b) Are not pregnant;

(c) Are not entitled to or enrolled for Medicare benefits under Part A or B of Title XVIII of the Social Security Act;

(d) Are not otherwise eligible for and enrolled in mandatory coverage under Missouri's MO HealthNet program in accordance with 42 CFR 435, Subpart B; and

(e) Have household income that is at or below one hundred percent of the federal poverty level for the applicable family size for the applicable year under the MAGI equivalent net income standard.

(2) The department shall immediately seek any necessary waivers from the federal Department of Health and Human Services to implement the provisions of this subsection. The waivers shall:

(a) Promote healthy behavior and reasonable requirements that patients take ownership of their health care by seeking early preventative care in appropriate settings, including no co-payments for preventive care services;

(b) Require personal responsibility in the payment of health care by establishing appropriate co-payments based on family income that shall discourage the use of emergency room visits for non-emergent health situations and promote responsible use of other health care services;

(c) Promote the adoption of healthier personal habits including limiting tobacco use or behaviors that lead to obesity;

(d) Allow recipients to receive an annual cash incentive to promote responsible behavior and encourage efficient use of health care services;

(e) Allow health plans to offer a health savings account option; and

(f) Include a request for an enhanced federal funding rate consistent with subsection 10 of this section for newly eligible participants.

(3) If such waivers and enhanced federal funding rate are not granted by the federal government, the provisions of this subsection shall be null and void.

4. Except for those individuals who meet the definition of medically frail, individuals eligible for MO HealthNet benefits under subsection 3 of this section shall receive only a package of alternative minimum benefits. The MO HealthNet division of the department of social services shall promulgate regulations to be effective January 1, 2014, that provide an alternative benefit package that complies with the requirements of federal law and is subject to limitations as established in regulations of the MO HealthNet division.

5. Except for those individuals who meet the definition of medically frail, individuals who qualify for coverage under subsections 2 and 3 of this section shall receive covered services through health plans authorized by the department under section 208.998.

6. The department shall provide premium subsidy and other cost supports for individuals eligible for MO HealthNet under subsections 2 and 3 of this section to enroll in employer-provided health plans or other private health plans based on cost-effective principles determined by the department.

7. Individuals eligible for MO HealthNet benefits under subsections 2 and 3 of this section who meet the definition of medically frail shall receive all benefits they are eligible to receive under

sections 208.152, 208.900, 208.903, 208.909, and 208.930.

8. The department shall establish a screening process in conjunction with the department of mental health and the department of health and senior services for determining whether an individual is medically frail and shall enroll all eligible individuals who meet the definition of medically frail and whose care management would benefit from being assigned a health home in the health home program or other care coordination as established by the department. Any eligible individual may opt out of the health home program.

9. The department or appropriate divisions of the department shall promulgate"; and

Further amend said bill and section, Pages 13 and 14, Lines 55 to 64, by renumbering all of the following subsections accordingly; and

Further amend said bill and section, Page 14, Line 67, by deleting all of said line and inserting in lieu thereof the following:

"of this section. The department shall request of the federal government an enhanced federal funding rate for persons newly eligible under subsection 3 of this section whereby the federal government agrees to pay the percentages specified in Section 2001 of Public Law 111-148, as that section existed on March 23, 2010. The provisions of subsections 3 to 8 of this section shall not be implemented unless such waivers and enhanced federal funding rates are granted by the federal government.

11. If at any time the director receives notice that the federal funds at the disposal of the state for payments of money benefits to or on behalf of any persons under subsection 3 of this section shall at any time become less than ninety percent of the funds necessary or are not appropriated to pay the percentages specified in Section 2001 of Public Law 111-148, as that section existed on March 23, 2010, subsections 3 to 8 of this section shall no longer be effective for the individuals whose benefits are no longer matchable at the specified percentages. The date benefits cease shall be stated in a notice sent to the affected individuals.

208.997. 1. The MO HealthNet division shall develop and implement the "Health Care Homes Program" as a provider-directed care coordination program for MO HealthNet recipients who are not enrolled in a prepaid MO HealthNet benefits option and who are receiving services on a fee-for-service basis. The health care homes program shall provide payment to primary care clinics for care coordination for individuals who are deemed medically frail. Clinics shall meet certain criteria, including but not limited to the following:

(1) The capacity to develop care plans;

(2) A dedicated care coordinator;

(3) An adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement; and

(4) The capability to maintain and use a disease registry.

2. For purposes of this section, "primary care clinic" means a medical clinic designated as the patient's first point of contact for medical care, available twenty-four hours a day, seven days a week, that provides or arranges the patient's comprehensive health care needs and provides overall integration, coordination, and continuity over time and referrals for specialty care. A primary care clinic may include a community mental health center.

3. The health care home for recipients of MO HealthNet services defined in paragraph (f) of subdivision (7) of subsection 1 of section 208.995 shall be the primary provider of home- and community-based services received by the recipient if such provider has a qualified, licensed designee to serve as the recipient's care coordinator and the provider can demonstrate the ability to meet the requirements in subsections 1 and 2 of this section. The qualifications for such designees

shall be defined by the department by rule.

4. Providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems and screening and brief intervention shall be reimbursed for utilizing the behavior assessment and intervention, and screening and brief intervention reimbursement codes 96150 to 96155 and 99408 to 99409 or their successor codes under the Current Procedural Terminology (CPT) coding system. Location of service may be limited to NCQA Level 3 Patient-Centered Medical Homes and CARF-accredited health homes.

5. The department may designate that the health care homes program be administered through an organization with a statewide primary care presence, experience with Medicaid population health management, and an established health homes outcomes monitoring and improvement system.

6. This section shall be implemented in such a way that it does not conflict with federal requirements for health care home participation by MO HealthNet participants.

7. The department or appropriate divisions of the department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2013, shall be invalid and void.

8. Nothing in this section shall be construed to limit the department's ability to create health care homes for participants in a managed care plan.

208.998. 1. Except for individuals who meet the definition of medically frail, individuals who qualify for coverage under subsections 2 and 3 of section 208.995 shall receive covered services through health plans offered by managed care entities which are authorized by the department. Health plans authorized by the department:

(1) Shall resemble commercially available health plans while complying with federal Medicaid requirements as authorized by federal law or through a federal waiver, and may include accountable care organizations, administrative service organizations, or managed care organizations paid on a capitated basis;

(2) Shall promote, to the greatest extent possible, the opportunity for children and their parents to be covered under the same plan;

(3) Shall offer plans statewide;

(4) Shall include cost sharing for outpatient services to the maximum extent allowed by federal law;

(5) May include other co-payments and provide incentives that encourage and reward the prudent use of the health benefit provided;

(6) Shall encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates;

(7) Shall provide incentives, including shared risk and savings, to health plans and providers to encourage cost-effective delivery of care;

(8) May provide multiple plan options and reward participants for choosing a low-cost plan; and

(9) Shall include the services of health providers as defined in 42 U.S.C. Section 1396d(l)(1) and (2) and meet the payment requirements for such health providers as provided in 42 U.S.C. Sections 1396a(a)(15) and 1396a(bb).

2. The department may designate that certain health care services be excluded from such

health plans if it is determined cost effective by the department.

3. (1) The department may accept regional plan proposals as an additional option for beneficiaries. Such proposals may be submitted by accountable care organizations or other organizations and entities.

(2) The department shall advance the development of systems of care for medically complex children who are recipients of MO HealthNet benefits by accepting cost-effective regional proposals from and contracting with appropriate pediatric care networks, pediatric centers for excellence, and medical homes for children to provide MO HealthNet benefits when the department determines it is cost effective to do so. Such entities shall be treated as accountable care organizations.

(3) The provisions of subsection 1 of this section shall not apply to this subsection.

4. The department shall establish, in collaboration with plans and providers, uniform utilization review protocols to be used by all authorized health plans.

5. The department shall establish a competitive bidding process for contracting with managed care plans.

(1) The department shall solicit bids only from bidders who offer, or through an associated company offer, an identical or substantially similar plan, in services provided and network, within a health care exchange in this state, whether federally facilitated, state based, or operated on a partnership basis. The bidder, if the bidder offers an identical or similar plan, in services provided or network continuity, including primary care providers, or the bidder and the associated company, if the bidder has formed a partnership for purposes of its bid, shall include a process in its bid by which MO HealthNet recipients who choose its plan will be automatically enrolled in the corresponding plan offered within the health care exchange if the recipient's income increases resulting in the recipient's ineligibility for MO HealthNet benefits. The bidder also shall include in its bid a process by which an individual enrolled in an identical or substantially similar plan, in services provided or network continuity, including primary care providers, within a health care exchange in this state, whether federally facilitated, state based, or operated on a partnership basis whose income decreases resulting in eligibility for MO HealthNet benefits shall be enrolled in MO HealthNet after an application is received and the participant is determined eligible for MO HealthNet benefits.

(2) The department shall select a minimum of three winning bids and may select up to a maximum number of bids equal to the quotient derived from dividing the total number of participants anticipated by the department in a region by one hundred thousand.

(3) The department shall accept the lowest conforming bid. For determining other accepted bids, the department shall consider the following factors:

(a) The cost to Missouri taxpayers;

(b) The extent of the network of health care providers offering services within the bidder's plan;

(c) Additional services offered to recipients under the bidder's plan;

(d) The bidder's history of providing managed care plans for similar populations in Missouri or other states;

(e) Any other criteria the department deems relevant to ensuring MO HealthNet benefits are provided to recipients in such manner as to save taxpayer money and improve health outcomes of recipients.

6. Any managed care organization that enters into a contract with the state to provide managed care plans shall be required to fulfill the terms of the contract and provide such plans for at least twelve months, or longer if the contract so provides. The state shall not increase the reimbursement rate provided to the managed care organization during the contract period above the rate included in the contract. If the managed care organization breaches the contract, the state shall be entitled to bring an action against the managed care organization for any remedy allowed by law

or equity and shall also recover any and all damages provided by law, including liquidated damages in an amount determined by the department during the bidding process. Nothing in this subsection shall be construed to preclude the department or the state of Missouri from terminating the contract as specified in the terms of the contract, including for breach of contract, lack of appropriated funds, or exercising any remedies for breach as may be provided in the contract.

7. (1) Participants enrolling in managed care plans under this section shall have the ability to choose their plan. In the enrollment process, participants shall be provided a list of all plans available ranked by the relative actuarial value of each plan. Each participant shall be informed in the enrollment process that he or she will be eligible to receive a portion of the amount saved by Missouri taxpayers if he or she chooses a lower cost plan offered in his or her region. The portion received by a participant shall be determined by the department according to the department's best judgment as to the portion which will bring the maximum savings to Missouri taxpayers.

(2) If a participant fails or refuses to choose a plan as set forth in subdivision (1) of this subsection, the department shall determine rules for auto-assignment, which shall include incentives for low-cost bids and improved health outcomes as determined by the department.

8. This section shall not be construed to require the department to terminate any existing managed care contract or to extend any managed care contract.

9. All MO HealthNet plans under this section shall provide coverage for the following services unless they are specifically excluded under subsection 2 of this section and instead are provided by an administrative services organization:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance abuse treatment, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness care, and chronic disease management;

(10) Pediatric services, including oral and vision care; and

(11) Any other services required by federal law.

10. No MO HealthNet plan or program shall provide coverage for an abortion unless a physician certifies in writing to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term.

11. The MO HealthNet program shall provide a high deductible health plan option for uninsured adults nineteen years of age or older and under sixty-five years of age with incomes of less than one hundred percent of the federal poverty level. The high deductible health plan shall include:

(1) After meeting a one thousand dollar deductible, coverage for benefits as specified by rule of the department;

(2) An account, funded by the department, of at least one thousand dollars per adult to pay medical costs for the initial deductible funded by the department;

(3) Preventive care, as defined by the department by rule, that is not subject to the deductible and does not require a payment of moneys from the account described in subdivision (2) of this subsection;

(4) A basic benefits package if annual medical costs exceed one thousand dollars;

(5) A minimum deductible of one thousand dollars;

(6) As soon as practicable, the establishment and maintenance of a record-keeping system for each health care visit or service received by recipients under this subsection. The plan shall

require that the recipient's prepaid card number be entered, or electronic strip be swiped, by the health care provider for purposes of maintaining a record of every health care visit or service received by the recipient from such provider, regardless of any balance on the recipient's card. Such information shall include only the date, provider name, and general description of the visit or service provided. The plan shall maintain a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped in accordance with this subdivision. If required under the federal Health Insurance Portability and Accountability Act (HIPAA) or other relevant state or federal law or regulation, a recipient shall, as a condition of participation in the prepaid card incentive, be required to provide a written waiver for disclosure of any information required under this subdivision;

(7) The determination of a proportion of the amount left in a participant's account described in subdivision (2) of this subsection which shall be paid to the participant for saving taxpayer money. The amount and method of payment shall be determined by the department; and

(8) The determination of a proportion of a participant's account described in subdivision (2) of this subsection which shall be used to subsidize premiums to facilitate a participant's transition from health coverage under MO HealthNet to private health insurance based on cost-effective principles determined by the department.

12. All participants with chronic conditions, as specified by the department, shall be included in an incentive program for MO HealthNet recipients who obtain specified primary care and preventive services, and who participate or refrain from participation in specified activities to improve the overall health of the recipient. Recipients who complete the requirements of the program shall be eligible to receive an annual cash payment for successful completion of the program. The department shall establish, by rule, the specific primary care and preventive services, activities to be included in the incentive program, and the amount of any annual cash payments to recipients.

13. A MO HealthNet recipient shall be eligible for participation in only one of either the high deductible health plan under subsection 11 of this section or the incentive program under subsection 12 of this section.

14. No cash payments, incentives, or credits paid to or on behalf of a MO HealthNet participant under a program established by the department under this section shall be deemed to be income to the participant in any means-tested benefit program unless otherwise specifically required by law or rule of the department.

15. Managed care entities shall inform participants who choose the high deductible health plan under subsection 11 of this section that the participant may lose his or her incentive payment under subdivision (7) of subsection 11 of this section if the participant utilizes visits to the emergency department for non-emergent purposes. Such information shall be included on every electronic and paper correspondence between the managed care plan and the participant.

16. The department shall provide participants formerly enrolled in the Ticket to Work Health Assurance Program any services formerly received under the program that are not provided through health insurance plans purchased through a health insurance exchange. These services shall include home health services, consumer directed services, Medicare Part D co-payments, durable medical equipment, psychiatric rehabilitation services, comprehensive substance treatment and rehabilitation, division of developmental disabilities waiver services, and targeted case management for mental health services.

17. The department shall seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services necessary to implement the provisions of this section. The provisions of this section shall not be implemented unless such waivers and state plan amendments are approved. If this section is approved in part by the federal government, the

department is authorized to proceed on those sections for which approval has been granted; except that, any increase in eligibility shall be contingent upon the receipt of all necessary waivers and state plan amendments. The provisions of this section shall not be implemented until eligibility of persons set out in subsection 3 of section 208.995 has been approved by the federal Department of Health and Human Services and has been implemented by the department. However, nothing shall prevent the department from expanding managed care for populations under other granted authority.

18. The department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as the term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2013, shall be invalid and void.

208.999. Subject to appropriations, the department shall develop incentive programs to encourage the construction and operation of urgent care clinics which operate outside normal business hours and are in or adjoining emergency room facilities which receive a high proportion of patients who are participating in MO HealthNet, to the extent that the incentives are eligible for federal matching funds.

376.961. 1. There is hereby created a nonprofit entity to be known as the "Missouri Health Insurance Pool". All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state shall be members of the pool.

2. Beginning January 1, 2007, the board of directors shall consist of the director of the department of insurance, financial institutions and professional registration or the director's designee, and eight members appointed by the director. Of the initial eight members appointed, three shall serve a three-year term, three shall serve a two-year term, and two shall serve a one-year term. All subsequent appointments to the board shall be for three-year terms. Members of the board shall have a background and experience in health insurance plans or health maintenance organization plans, in health care finance, or as a health care provider or a member of the general public; except that, the director shall not be required to appoint members from each of the categories listed. The director may reappoint members of the board. The director shall fill vacancies on the board in the same manner as appointments are made at the expiration of a member's term and may remove any member of the board for neglect of duty, misfeasance, malfeasance, or nonfeasance in office.

3. Beginning August 28, 2007, the board of directors shall consist of fourteen members. The board shall consist of the director and the eight members described in subsection 2 of this section and shall consist of the following additional five members:

(1) One member from a hospital located in Missouri, appointed by the governor, with the advice and consent of the senate;

(2) Two members of the senate, with one member from the majority party appointed by the president pro tem of the senate and one member of the minority party appointed by the president pro tem of the senate with the concurrence of the minority floor leader of the senate; and

(3) Two members of the house of representatives, with one member from the majority party appointed by the speaker of the house of representatives and one member of the minority party appointed by the speaker of the house of representatives with the concurrence of the minority floor leader of the house of representatives.

4. The members appointed under subsection 3 of this section shall serve in an ex officio capacity. The terms of the members of the board of directors appointed under subsection 3 of this section shall expire on December 31, 2009. On such date, the membership of the board shall revert

back to nine members as provided for in subsection 2 of this section.

5. Beginning on August 28, 2013, the board of directors on behalf of the pool, the executive director, and any other employees of the pool shall have the authority to provide assistance or resources to any department, agency, public official, employee, or agent of the federal government for the specific purpose of transitioning individuals enrolled in the pool to coverage outside of the pool beginning on or before January 1, 2014. Such authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange.

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 or third-party administrator in accordance with section 376.968;

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

(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**]**.

3. On or before September 1, 2013, the board shall submit such amendments to the plan of operation as are necessary or suitable to ensure a reasonable transition period to allow for the termination of issuance of policies by the pool.

4. The amendments to the plan of operation submitted by the board shall include all of the requirements outlined in subsection 2 of this section and shall address the transition of individuals covered under the pool to alternative health insurance coverage as it is available after January 1, 2014. The plan of operation shall also address procedures for finalizing the financial matters of the pool, including assessments, claims expenses, and other matters identified in subsection 2 of this section.

5. The director shall review the plan of operation submitted under subsection 3 of this section and shall promulgate rules to effectuate the transitional plan of operation. Such rule shall be effective no later than October 1, 2013. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2013, shall be invalid and void.

376.964. The board of directors and administering insurers of the pool shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health insurance as defined in section 376.960, and, in addition thereto, the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of sections 376.960 to 376.989, including the authority, with the approval of the director, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(3) Take such legal actions as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(4) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(5) Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year;

(6) Prior to January 1, 2014, issue policies of insurance in accordance with the requirements of sections 376.960 to 376.989. In no event shall new policies of insurance be issued on or after January 1, 2014;

(7) Appoint, from among members, appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy or other contract design, and any other function within the authority of the pool;

(8) Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers;

(9) Negotiate rates of reimbursement with health care providers on behalf of the association and its members;

(10) Administer separate accounts to separate federally defined eligible individuals and trade act eligible individuals who qualify for plan coverage from the other eligible individuals entitled to pool coverage and apportion the costs of administration among such separate accounts.

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. Prior to January 1, 2014, 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.

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 two hundred percent 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;

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

(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 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. Coverage under the pool shall expire on January 1, 2014.

376.968. The board shall select an insurer **[**or**]** , insurers, or third-party administrators through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The insurer's proven ability to handle individual accident and health insurance;

(2) The efficiency of the insurer's claim-paying procedures;

(3) An estimate of total charges for administering the plan;

(4) The insurer's ability to administer the pool in a cost-efficient manner.

376.970. 1. The administering insurer shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

2. The administering insurer shall:

(1) Perform all eligibility and administrative claim-payment functions relating to the pool;

(2) Establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a period basis as determined by the board;

(3) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;

(b) Evaluating the eligibility of each claim for payment by the pool;

(4) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be determined by the board;

(5) Following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form prescribed by the director;

(6) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

3. On or before September 1, 2013, the board shall invite all insurers and third-party administrators, including the current administering insurer, to submit bids to serve as the administering insurer or third-party administrator for the pool. Selection of the administering insurer or third-party administrator shall be made prior to January 1, 2014.

4. Beginning January 1, 2014, the administering insurer or third-party administrator shall:

(1) Submit to the board and director a detailed plan outlining the winding down of operations of the pool. The plan shall be submitted no later than January 31, 2014, and shall be updated quarterly thereafter;

(2) Perform all administrative claim-payment functions relating to the pool;

(3) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made; and

(b) Evaluating the eligibility of each claim for payment by the pool;

(4) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be determined by the board;

(5) Following the close of each calendar year, determine the expense of administration, and the paid and incurred losses for the year, and report such information to the board and department on

a form prescribed by the director; and

(6) Be paid as provided in the plan of operation for its expenses incurred in the performance of its 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.

5. Assessments shall continue until such time as the director of the pool provides notice to the board and director that all claims have been paid.

6. Any assessment funds remaining at the time the director provides notice that all claims have been paid shall be deposited in the state general revenue fund.

Section 1. 1. Notwithstanding any other provision of law to the contrary, beginning July 1, 2014, any MO HealthNet recipient who elects to receive medical coverage through a private health insurance plan instead of through the MO HealthNet program shall be eligible for a private insurance premium subsidy to assist the recipient in paying the costs of such private insurance if it is determined to be cost effective by the department. The subsidy shall be provided on a sliding scale based on income, with a graduated reduction in subsidy over a period of time not to exceed two years.

2. The department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2013, shall be invalid and void."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.