HCS#2 HB 1793 -- PROVISION OF HEALTH CARE

SPONSOR: Frederick

COMMITTEE ACTION: Voted "Do Pass" by the Committee on Health Care Policy by a vote of 9 to 2.

This bill changes the laws regarding the provision of health care.

COST ESTIMATES (Section 191.875, RSMo)

On or after July 1, 2015, any patient or consumer of health care services, or any MO HealthNet recipient or the division on behalf of a MO HealthNet recipient under Section 208.187 who makes a request for an estimate of the cost of health care services from a health care provider must be provided the estimate no later than five business days after receiving the request, except when the requested information is posted on the Department of Health and Senior Services website under these provisions. These provisions must not apply to emergency health care services. "Estimate of cost" is defined as an estimate based on the information entered and assumptions about typical utilization and costs for health care services. The estimate of cost must include:

(a) The amount that will be charged to a patient for the health services if all charges are paid in full without a public or private third party paying for any portion of the charges;

(b) The average negotiated settlement on the amount that will be charged to a patient;

(c) The amount of any MO HealthNet reimbursement for the health care services, including claims and pro rata supplemental payments, if known;

(d) The amount of any Medicare reimbursement for the medical services, if known; and

(e) The amount of any insurance co-payments for the health benefit plan of the patient, if known.

Health care providers and the department must include with any estimate a specified disclaimer stating that the estimated cost is an estimate and may be different from the actual amount billed and is not a guarantee of insurance coverage or payment of benefits by a public or private third party. Each health care provider must also make available the percentage or amount of any discounts for cash payment of any charges incurred by a posting on the provider's website and by making it available at the provider's location.

Nothing in these provisions must be construed as violating any provider contract provision with a health carrier that prohibits disclosure of the provider's fee schedule with a health carrier to third parties.

A hospital may provide the information specified in these provisions to the department. A hospital that does so must not be required to provide the information to a patient or health care consumer as specified in these provisions. The department must make available to the public on its internet website the most current price information it receives from hospitals under these provisions. The department must provide the information in a manner that is easily understood by the public and meets the following minimum requirements:

(1) Information for each participating hospital must be listed separately and hospitals must be listed in groups by category as determined by the department by rule; and

(2) Information for each hospital outpatient department must be listed separately.

Any data disclosed to the department by a hospital under these provisions must be the sole property of the hospital that submitted the data. Any data or product derived from the data disclosed under these provisions, including a consolidation or analysis of the data, must be the sole property of the state. The department must not allow proprietary information it receives or discloses under these provisions to be used by any person or entity for commercial purposes.

Beginning with the quarter ending June 30, 2015, and quarterly thereafter, each participating hospital must provide to the department, in the manner and format determined by the department, the following information about the 100 most frequently reported admissions by a diagnosis related group for inpatients as established by the department:

(1) The amount that will be charged to a patient for each diagnosis related group if all charges are paid in full without a public or private third party paying for any portion of the charges;

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided these provisions;

(3) The amount of Medicaid reimbursement for each diagnosis related group, including claims and pro rata supplemental payments; and

(4) The amount of Medicare reimbursement for each diagnosis related group.

A hospital must not report or be required to report the information required by these provisions for any of the 100 most frequently reported admissions where the reporting of the information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

Beginning with the quarter ending June 30, 2015, and quarterly thereafter, each participating hospital must provide to the department, in a manner and format determined by the department, information on the total costs for the 50 most common outpatient surgical procedures by Current Procedure Terminology code and the 50 most common imaging procedures by Current Procedure Terminology code performed in hospital outpatient settings. Participating hospitals must report this information in the same manner as required for the 100 most frequently reported admissions; provided that hospitals must not report or be required to report the information required in these provisions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of HIPAA or other federal law.

The department must promulgate rules to implement these provisions, which must include all of the following:

(1) The 100 most frequently reported diagnosis related groups for inpatients for which participating hospitals will provide the data set out in subsection 10 of this section;

(2) Specific categories by which hospitals must be grouped for the purpose of disclosing this information to the public on the department's internet website; and

(3) In accordance with these provisions, the list of the 50 most common outpatient surgical procedures by Current Procedure Terminology code and the 50 most common imaging procedures by Current Procedure Terminology code performed in a hospital outpatient setting.

MO HEALTHNET ASSET LIMITS (Section 208.010)

The maximum amount of cash, securities, or other total non-exempt assets an aged or disabled person is allowed to own or possess in order to qualify for MO HealthNet benefits is increased from $1,000

to $2,000 for a single person and from $2,000 to $4,000 for a married couple. The bill also increases, from $1,000 to $2,000, the resource limit excluding the home occupied by the claimant for benefits under the Temporary Assistance for Needy Families (TANF) Program.

MO HEALTHNET PATIENT-CENTERED CARE ACT OF 2014 (Section 208.187)

The MO HealthNet Patient-centered Care Act of 2014 is established that requires, beginning July 1, 2015, or upon termination of any current contracted health plan in the pilot project areas and subject to receipt of any necessary state plan amendments or waivers from the federal Department of Health and Human Services, the MO HealthNet Division within the Department of Social Services to establish the "MO HealthNet Patient-centered Care Pilot Program" that transfers current MO HealthNet recipients in the pilot project areas to an approved health plan arrangement wherein recipients may purchase health services through individual health savings accounts and implement an electronic benefit transfer (EBT) payment system for participating recipients.

The MO HealthNet division must establish a minimum of three, but not more than six, pilot project areas in this state that must include at least 10% of the total MO HealthNet recipient population, excluding the aged, blind, and disabled population, in the first two years of the pilot project. In the third year of the pilot project, the division may increase the total number of pilot project areas to not more than 10 and must increase the number of participants to at least 20% of the total MO HealthNet recipient population, excluding the aged, blind, and disabled population. If the pilot project is automatically implemented on a statewide basis these provisions must apply to every MO HealthNet recipient, excluding the aged, blind, and disabled population. To ensure an accurate sampling of MO HealthNet recipients, the demographics of the pilot project population must reflect, to the extent practicable within the geographic area served by the system, the current percentages of recipients in the MO HealthNet program population regarding age, gender, socioeconomic status, healthy versus chronically ill populations, urban versus rural populations, and other relevant demographics as determined by the division. Nothing in these provisions must be construed as requiring the division to obtain the exact and precise demographics of the current MO HealthNet recipient population in the pilot project or to include or exclude recipients based solely on the pilot project demographic requirements. The division must compile and include a summary of the demographic information for the pilot project and the current MO HealthNet program in the reports required in these provisions.

The pilot project must be supported by a health management and population analytics system that tracks and monitors health outcomes in traditionally challenging populations, such as mothers at risk for premature births, frequent utilizers of emergency departments, and those suffering from chronic pain conditions. The system must implement clinically based predictive models and interventions to improve the care coordination for the targeted populations within the pilot area.

Under the pilot project, the division must:

(1) Require recipients to receive benefits and services through an approved health plan arrangement;

(2) Require the use of EBT cards issued to participating recipients to pay for MO HealthNet services;

(3) Require recipients to receive an annual examination within six months of enrollment;

(4) Provide educational opportunities for recipients relating to budgeting, planning, and appropriate use of health care options;

(5) Provide assistance and education to recipients and providers which encourages:

(a) Recipients to seek an estimate of cost for health care service under Section 191.875 prior to receipt of health care services and providers to provide the estimate of cost prior to receipt of health care services; and

(b) Providers to work with recipients to assist them in making the best and most cost-effective choices available based on the recipient's medical needs.

The division is authorized to request an estimate of cost on the recipient's behalf under Section 191.875 and assist recipients, in collaboration with their providers, in making good health care choices and the best use of their health savings account moneys based on the recipient's approved health plan arrangement.

(6) Provide incentives for recipients to seek health care services as needed, while retaining a portion of any savings achieved from efficient use of their EBT cards;

(7) Provide moneys to recipients for health savings accounts, payment of health insurance premiums, and other health-related costs to recipients;

(8) Provide reimbursement of any willing providers licensed in this state and eligible to provide services under the terms of the pilot project at a rate of one hundred percent of the Medicare reimbursement rate for the same or similar services provided; and

(9) Provide demographic and cost-efficiency information to determine feasibility of statewide implementation of the EBT payment system; and

(10) Allow recipients to designate a third party to act on behalf of the participating recipient in case of incapacity, incompetence, or other physical or mental condition as determined by rule of the division which necessitates a designee to act on behalf of the participating recipient. If no designee is selected by a participating recipient, the division must act on behalf of the participating recipient.

Under the pilot project, the government assistance amount necessary to fund the pilot project must be determined annually based on a survey of the commercial health market in this state and establishing the average cost of an approved health plan arrangement which is composed of direct primary care services and a high-deductible insurance plan. The average cost must be the government assistance amount deposited in the MO HealthNet Health Savings Account Trust Fund. These provisions specify the requirements regarding the health savings accounts and the MO HealthNet Health Savings Account Trust Fund.

Pilot project recipients must receive a prepaid EBT card to pay for MO HealthNet services received through an approved health plan arrangement, including but not limited to payment of deductible amounts. The division must determine the amount credited to the EBT card from the recipient's health savings account for each recipient on a risk adjusted basis and in accordance with these provisions. Providers in the MO HealthNet pilot project must be required to swipe a recipient's EBT card for every visit or service received regardless of the balance on the recipient's EBT card. Subject to any federal and state laws, the division must maintain a record of every visit or service received by a recipient, regardless of whether payment was obtained from a recipient's EBT card. Participating recipients must be required to permit and if required sign a waiver for, disclosure of the information required in this subsection to the division. Nothing in this subsection must be construed as requiring the division to maintain specific medical records of recipients. The disclosure required under this section must be limited to name of the provider, date, and general nature of the visit or service.

These provisions specify how any remaining balance on a recipient's

EBT card at the end of the benefit year must be apportioned to the recipient. Any balance not apportioned to the recipient under these provisions must revert to the division. Any reverted amounts which, in the aggregate, total 25% or less of the total amounts credited on all EBT cards under the pilot project must be deposited in the MO HealthNet health savings account trust fund. The division must reassess the amount of MO HealthNet moneys allocated for the pilot project based on the amounts reverting to the division.

Beginning July 1, 2017, unless these provisions are repealed by an act of the General Assembly, the pilot project must automatically be implemented on a statewide basis for all MO HealthNet recipients who are eligible to receive MO HealthNet benefits in accordance with federal law and state plan amendments and waivers.

ASSISTANT PHYSICIANS (Section 334.036)

The bill establishes provisions for the licensing of an assistant physician. An assistant physician is any medical school graduate who is a resident and citizen of the United States or is a legal resident alien, has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of the steps of any other board-approved medical licensing examination within the two-year period immediately preceding application for licensure as an assistant physician, but in no event more than three years after graduation from a medical college or osteopathic medical college, has not completed an approved postgraduate residency, has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent as specified in the bill, and has proficiency in the English language.

An assistant physician collaborative practice arrangement must limit the assistant physician to providing only primary care services and only in medically underserved rural or urban areas of this state or in any pilot project areas established in which assistant physicians may practice. For a physician-assistant physician team working in a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended, an assistant physician must be considered a physician assistant for purposes of regulations of the Centers for Medicare and Medicaid Services (CMS) and no supervision requirements in addition to the minimum federal law must be required.

For purposes of these provisions, the licensure of assistant physicians must take place within processes established by rules of the State Board of Registration for the Healing Arts within the Department of Insurance, Financial Institutions and Professional Registration. An application for licensure may be denied or the

licensure of an assistant physician may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by Section 334.100, or the other standards of conduct set by the board by rule.

An assistant physician must clearly identify himself or herself as an assistant physician and must be permitted to use the terms "doctor," "Dr.," or "doc." An assistant physician is prohibited from practicing or attempting to practice without an assistant physician collaborative practice arrangement, except as otherwise provided in these provisions and in an emergency situation. The collaborating physician is responsible at all times for the oversight of the activities of, and accepts responsibility for, primary care services rendered by the assistant physician.

The provisions of Section 334.037, governing collaborative practice agreements, must apply to all assistant physician collaborative practice arrangements. To be eligible to practice as an assistant physician, a licensed assistant physician must enter into an assistant physician collaborative practice arrangement within six months of his or her initial licensure and must not have more than a six-month time period between collaborative practice arrangements during his or her licensure period. Any renewal of licensure under these provisions must include verification of actual practice under a collaborative practice arrangement during the immediately preceding licensure period.

ASSISTANT PHYSICIAN COLLABORATIVE PRACTICE ARRANGEMENT (Section 334.037)

Physicians may enter into a collaborative practice arrangement with an assistant physician. Collaborative practice arrangements must be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which must be in writing, may delegate to an assistant physician the authority to administer or dispense drugs and provide treatment as long as the delivery of the health care services is within the scope of practice of the assistant physician and is consistent with that assistant physician's skill, training, and competence and the skill and training of the collaborating physician.

The written collaborative practice arrangement must contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the assistant physician;

(2) A list of all other offices or locations besides those listed above where the collaborating physician authorized the assistant physician to prescribe;

(3) A requirement that there must be posted at every office where the assistant physician is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an assistant physician and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the assistant physician;

(5) The manner of collaboration between the collaborating physician and the assistant physician, including how the collaborating physician and the assistant physician must:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity, except the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of 28 days per calendar year for rural health clinics as defined by Public Law 95-210, as long as the collaborative practice arrangement includes alternative plans as required in these provisions. The exception to geographic proximity must apply only to independent rural health clinics, provider-based rural health clinics where the provider is a critical access hospital, and provider-based rural health clinics where the main location of the hospital sponsor is greater than 50 miles from the clinic. The collaborating physician must maintain documentation related to the requirement and present it to the state board of registration for the healing arts when requested; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the assistant physician's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the assistant physician to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice agreements of the collaborating physician and the assistant physician;

(8) The duration of the written practice agreement between the

collaborating physician and the assistant physician;

(9) A description of the time and manner of the collaborating physician's review of the assistant physician's delivery of health care services. The description must include provisions that the assistant physician must submit a minimum of 10% of the charts documenting the assistant physician's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every 14 days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, must review every 14 days a minimum of 20% of the charts in which the assistant physician prescribes controlled substances. The charts reviewed under these provisions may be counted in the number of charts required to be reviewed under these provisions.

The bill requires the State Board of Registration for the Healing Arts to promulgate rules regulating the use of collaborative practice arrangements for assistant physicians. The rules must specify geographic areas to be covered; the methods of treatment that may be covered by collaborative practice arrangements; in conjunction with deans of medical schools and primary care residency program directors in the state, the development and implementation of educational methods and programs undertaken during the collaborative practice service which must facilitate the advancement of the assistant physician's medical knowledge and capabilities, and which may lead to credit toward a future residency program for programs that deem the documented educational achievements acceptable; and the requirements for review of services provided under collaborative practice arrangements, including delegating authority to prescribe controlled substances.

Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section must be subject to the approval of the State Board of Pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section must be subject to the approval of the Department of Health and Senior Services and the State Board of Pharmacy. The State Board of Registration for the Healing Arts must promulgate rules applicable to assistant physicians which must be consistent with guidelines for federally funded clinics. The rulemaking authority granted in this subsection must not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined in Chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

The bill prohibits the State Board of Registration for the Healing Arts from denying, revoking, suspending or otherwise taking disciplinary action against a collaborating physician for health care services delegated to an assistant physician provided under these provisions.

Within 30 days of any change and on each renewal, the State Board of Registration for the Healing Arts must require every physician to identify whether the physician is engaged in any collaborative practice agreement, including collaborative practice agreements delegating the authority to prescribe controlled substances, and also report to the board the name of each assistant physician with whom the physician has entered into an agreement. The board may make the information available to the public. The board must track the reported information and may routinely conduct random reviews of agreements to ensure that agreements are carried out for compliance under these provisions.

A collaborating physician is prohibited from entering into a collaborative practice arrangement with more than three full-time equivalent assistant physicians. The limitation must not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in Chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

The collaborating physician must determine and document the completion of at least a one-month period of time during which the assistant physician must practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. The limitation must not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008. No agreement made under these provisions must supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in Section 197.020 if the protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

No contract or other agreement must require a physician to act as a collaborating physician for an assistant physician against the physician's will. A physician must have the right to refuse to act as a collaborating physician, without penalty, for a particular assistant physician. No contract or other agreement must limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority

to any assistant physician, but the requirement must not authorize a physician in implementing the protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff. No contract or other agreement must require any assistant physician to serve as a collaborating assistant physician for any collaborating physician against the assistant physician's will. An assistant physician must have the right to refuse to collaborate, without penalty, with a particular physician.

All collaborating physicians and assistant physicians in collaborative practice arrangements must wear identification badges while acting within the scope of their collaborative practice arrangement. The identification badges must prominently display the licensure status of the collaborating physicians and assistant physicians.

WORKFORCE PLANNING BY THE STATE BOARD OF NURSING (Sections 335.036 - 335.380)

The bill authorizes the State Board of Nursing within the Department of Insurance, Financial Institutions and Professional Registration to enter into a contractual agreement with the Missouri Nurses Foundation Center for Advancing Health, a nonprofit organization established for the purpose of creating a comprehensive nurse workforce center to assess and improve the nursing workforce and its distribution. This center may enter into a contractual agreement with a public institution of higher education for the purpose of collecting and analyzing workforce data from its licensees for future workforce planning. The board may release identifying data to the contractor to facilitate data analysis of the healthcare workforce including geographic, demographic, and practice or professional characteristics of licensees. The contractor must maintain the confidentiality of information it receives from the board and can only release information in an aggregate form that cannot be used to identify the individual.

The bill creates the Nursing Workforce Center Fund to be managed by the state board. The board must collect at the time of licensure or licensure renewal a $5 per year surcharge from each registered professional nurse and licensed practical nurse that must be deposited in the fund in addition to appropriated moneys, contributions, grants, and federal funds to pay all administrative costs and expenses incurred from the implementation of these provisions.

PRESCRIPTION CO-PAYMENTS (Sections 354.535 and 376.387)

If the co-payment applied by a health maintenance organization, health insurer, or health carrier exceeds the usual and customary retail price of the prescription drug, the pharmacy must inform the enrollee that the usual and customary price of the prescription drug is lower than the co-payment for the drug through the enrollee's plan. The enrollee may opt to pay the usual and customary retail price of the prescription drug instead of submitting the claim for payment through the enrollee's plan.

MEDICAL CLINICS IN MEDICALLY UNDERSERVED AREAS (Section 1)

This bill requires the Department of Health and Senior Services to establish and administer a program to increase the number of medical clinics in medically underserved areas.

The bill defines "medically underserved area" as an area in this state with a medically underserved population; an area in this state designated by the United States Secretary of Health and Human Services as an area with a shortage of personal health services; a population group designated by the United States Secretary of Health and Human Services as having a shortage of personal health services; an area designated under state or federal law as a medically underserved community; or an area that the department considers to be medically underserved based on relevant demographic, geographic, and environmental factors.

The bill defines "start-up money" as a payment made by a county or municipality in this state that includes a medically underserved area for reasonable costs incurred for the establishment of a medical clinic, ancillary facilities for diagnosing and treating patients, and payment of physicians, assistant physicians, and any support staff.

A county or municipality in this state that includes a medically underserved area may establish a medical clinic in the medically underserved area by contributing start-up money for the medical clinic and having the contribution matched wholly or partly by grant moneys from the medical clinics in medically underserved areas fund established in these provisions. The department is required to seek all available moneys from any source whatsoever, including but not limited to moneys from the Missouri Foundation for Health, to assist in funding the program. A participating county or municipality that includes a medically underserved area may provide start-up money for a medical clinic over a two-year period. The department must not provide more than $100,000 to such county or municipality in a fiscal year unless the department makes a specific finding of need in the medically underserved area. The department must establish priorities so that the counties or municipalities that include the neediest medically underserved

areas eligible for assistance under these provisions are assured the receipt of a grant.

The bill creates the Medical Clinics in Medically Underserved Areas Fund within the state treasury. The fund must consist of any state moneys appropriated, gifts, grants, donations, or any other contribution from any source for such purpose. The State Treasurer must be custodian of the fund and may approve disbursements. The fund must be a dedicated fund and, upon appropriation, money in the fund must be used solely for the administration of these provisions. Any moneys remaining in the fund at the end of the biennium must not revert to the credit of the General Revenue Fund. The state treasurer must invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on the investments must be credited to the fund.

To be eligible to receive a matching grant from the department, a county or municipality that includes a medically underserved area must apply for the matching grant and provide evidence satisfactory to the department that it has entered into an agreement or combination of agreements with a collaborating physician(s) for the collaborating physician(s) and assistant physician(s) in accordance with a collaborative practice agreement under Section 334.037 to provide primary care in the medically underserved area for at least two years.

The department is required to promulgate rules necessary for the implementation of these provisions, including rules addressing:

(1) Eligibility criteria for a medically underserved area;

(2) A requirement that a medical clinic utilize an assistant physician in a collaborative practice arrangement under Section 334.037;

(3) Minimum and maximum county or municipality contributions to the start-up money for a medical clinic to be matched with grant moneys from the state;

(4) Conditions under which grant moneys must be repaid by a county or municipality for failure to comply with the requirements for receipt of such grant moneys;

(5) Procedures for disbursement of grant moneys by the department;

(6) The form and manner in which a county or municipality must make its contribution to the start-up money; and

(7) Requirements for the county or municipality to retain interest

in any property, equipment, or durable goods for seven years, including but not limited to the criteria for a county or municipality to be excused from the retention requirement.

PROPONENTS: Supporters say that Medicaid is a broken system that needs to be addressed and the bill contains substantial reforms. In order to fix the broken system we need to focus on health care outcomes, access to care, quality of care, and transparency. The exchange of electronic medical records via health information exchanges could save the state a substantial amount of money and improve health outcomes. The bill places pilot programs in existing health information exchange areas, thus allowing providers to pool the data and will prevent duplicative treatment and tests and lead to lower health care costs overall.

Testifying for the bill were Representative Frederick; Cerner Corporation; and United for Missouri.

OPPONENTS: Those who oppose the bill say that they have a problem with the language regarding the right to contract with an attorney.

Testifying against the bill was Missouri Association of Trial Attorneys.

OTHERS: Others testifying on the bill say legislators need to think outside the box and need to move on from managed care. Managed care has failed everyone but big business. The term "anesthetists" is confusing and does not agree with current Missouri law.

Testifying on the bill were Dr. Helen Gelhot and Cassandra Decker, Missouri Association of Nurse Anesthestists.