HCS SS#2 SB 79 -- HEALTH CARE

SPONSOR: Gregory (021)

COMMITTEE ACTION: Voted "Do Pass with HCS" by the Standing Committee on Health and Mental Health by a vote of 15 to 1. Voted "Do Pass" by the Standing Committee on Rules-Legislative by a vote of 7 to 0.

The following is a summary of the House Committee Substitute for SB 79.

This bill modifies several provisions relating to health care.

HOSPITALS (Sections 96.192, 96.196, 206.110, and 206.158)

This bill authorizes, but does not require, the board of trustees of certain hospitals to invest up to 50% of the hospital's available funds, defined in the bill, into certain mutual funds, bonds, money market investments, or a combination thereof. This permission only applies if the hospital receives less than 3% of its annual revenue from municipal, county, or state taxes, as well as if the hospital receives less than 3% of its annual revenue from appropriated funds from the municipality in which the hospital is located. Following that, the remaining percentage of any available funds not invested as allowed are required to be invested into any investment in which the State Treasurer is allowed to invest.

Additionally, with the exception of counties of the third and fourth classification where there already exists a hospital organized under Chapters 96, 205, or 206, RSMo, county commissions are authorized to establish, construct, equip, improve, extend, repair, and maintain public hospitals, engage in health care activities, and issue bonds.

This bill removes the exception for hospitals established under the provisions of Chapters 96 and 206 in counties of the third and fourth classification. The bill authorizes, but does not require, the board of directors of any hospital district that receives less than 3% of its annual revenues from hospital district or state taxes to invest up to 50% of its available funds, defined in the bill, into certain mutual funds, bonds, money market investments, or a combination thereof. Following that, the remaining percentage of any available funds not invested as allowed are required to be invested into any investment in which the State Treasurer is allowed to invest.

AMBULANCE DISTRICT BOARDS OF DIRECTORS (Section 190.053)

The bill modifies training requirements for members of an ambulance district's board of directors. Under this bill, board members must complete three hours of continuing education for each term of office. Failure to do so will result in immediate disqualification and the office will be vacant until filled.

AMBULANCE DISTRICT AUDITS (Section 190.076)

The bill requires each ambulance district to arrange for an audit of the district's records and accounts every three years by a certified public accountant. The audit must be made available to the public on the district's website or otherwise freely available by other electronic means.

COMMUNITY PARAMEDICS (Section 190.098)

This bill modifies provisions relating to certification of community paramedics and the provision of community paramedic services. Currently, community paramedics practice in accordance with protocols and supervisory standards of the ambulance service's medical director. Ambulance services that provide community paramedic services in another ambulance service area must enter into a written contract to do so. The bill repeals these provisions.

Under this bill, community paramedic services mean those services provided by an entity that employs licensed paramedics certified by the Department of Health and Senior Services as community paramedics for services that are provided in a non-emergent setting, consistent with the education and training of a community paramedic and the supervisory standard approved by the medical director, and documented in the entity's patient care plans or protocols. Any ambulance service that seeks to provide community paramedic services outside of its service area must have a memorandum of understanding (MOU) with the ambulance service of that area if that ambulance service is already providing those services or must notify the ambulance services of that area if that ambulance service is not providing community paramedic services. Emergency medical response agencies (EMRA) may provide community paramedic services in a ground ambulance service's service area. If the ground ambulance service is already providing those services or provides them after the EMRA offers them, then the EMRA and ground ambulance service must enter into an MOU for the coordination of services. The Department will promulgate rules and regulations for the purpose of certifying community paramedic services entities and the standards necessary to provide the services. Certified entities are eligible to provide community paramedic services for five years.

STATE ADVISORY COUNCIL ON EMERGENCY MEDICAL SERVICES (Section 190.101)

The bill modifies the State Advisory Council on Emergency Medical Services by changing the number of council members from 16 to no more than 23 and specifying the members who will serve on the Council. Currently, members are appointed by the Governor with the advice and consent of the Senate. Under this bill, the Director of the Department of Health and Senior Services, the regional EMS advisory committees, and the Time-Critical Diagnosis Advisory Committee will appoint members.

AMBULANCE LICENSES (Sections 190.109, 190.112, and 190.166)

The Department of Health and Seniors Services, as a part of regulating ground ambulance service licenses, will promulgate rules regarding participation with regional emergency medical services advisory committees and ambulance service administrator qualifications. The bill requires ambulance services to report to the Department individuals serving as ambulance service administrators. These administrators are required to complete training as provided in the bill.

Finally, the Department may refuse to issue, deny renewal of, or suspend a license required for ground ambulance services or take other corrective actions if the license holder is determined to be financially insolvent, has inadequate personnel for the service provided, requires an inordinate amount of mutual aid from neighboring services, has been determined to be criminally liable for actions related to the license or service provided, has been determined to be ineligible for participation in Medicare or MO HealthNet, whose ambulance district administrator has failed to meet the required qualifications or training, or if three or more board members have failed to complete required training.

If the Department makes a determination of insolvency or insufficiency of services, then the Department may require the license holder to submit and complete a corrective plan, as specified in the bill. The Department is required to provide notice of any determination of insolvency or insufficiency of services to other license holders operating in the license holder's vicinity, members of the General Assembly who represent that area, other governing officials, the appropriate regional emergency medical services advisory committee, and the State Advisory Council on Emergency Medical Services.

The Department must immediately engage with other license holders in the area to determine how ground ambulance services may be provided to the affected area during the service disruption.

Assisting license holders may be compensated for the assistance as provided in the bill.

GROUND AMBULANCE SERVICE REIMBURSEMENT ALLOWANCE TAX (Section 190.800)

For the purposes of reimbursement allowance taxes, current law exempts ambulance services that are owned and operated by an entity owned and operated by the state of Missouri from being required to pay an ambulance service reimbursement allowance tax. This bill repeals that exemption.

SEXUALLY TRANSMITTED INFECTIONS (Section 191.648)

Currently, a physician may utilize expedited partner therapy, meaning the practice of treating the sex partners of persons with chlamydia or gonorrhea without an intervening medical evaluation or professional prevention counseling, to prescribe and dispense medications for the treatment of chlamydia or gonorrhea even without an established physician/patient relationship. Under this bill, certain health care professionals may use expedited partner therapy and the therapy may be used for designated sexually transmitted infections beyond chlamydia and gonorrhea.

The bill repeals the requirement that antibiotic medications prescribed and dispensed through expedited partner therapy for the treatment of chlamydia or gonorrhea be in pill form.

TELEHEALTH SERVICES (Sections 191.1145, 191.1146, and 334.108)

Under this bill, "telehealth" or "telemedicine" includes the delivery of health care services through audiovisual and audio-only technologies and can not be limited only to services delivered via select third-party corporate platforms.

Currently, the establishment of a physician-patient relationship for purposes of telehealth includes an interview and a physical examination. Under this bill, an evaluation is still required, but a physical examination is required only if needed to meet the standard of care.

Current law prohibits the use of an internet or telephone questionnaire completed by a patient from constituting an acceptable medical interview for the provision of treatment by telehealth. This bill permits the questionnaires if the information provided is sufficient as though the medical evaluation was performed in person, and provided that the physician is employed or contracted with a business entity licensed to provide health care in this state. When a health care provider uses an

online or telephone questionnaire the provider must send a written report to the primary care provider if the patient provides their primary care provider information. The report must be sent within 14 days of the appointment and contain specified information, including the diagnosis and any treatment.

Current law requires a physician-patient relationship for purposes of telehealth to include a sufficient dialogue with the patient regarding treatment. This bill changes "dialogue" to "exchange" with the patient regarding treatment.

Finally, current law prohibits a health care provider from prescribing any drug, controlled substance, or other treatment to a patient based solely on an internet request or questionnaire. Under this bill, a health care provider must not prescribe any drug, controlled substance, or other treatment to a patient in the absence of a proper provider-patient relationship.

SPECIALTY HOSPITALS (Section 192.2521)

This bill provides that a "specialty hospital", defined as a hospital that has been designated by the Department of Health and Senior Services as something other than a general acute care hospital, is exempt from two provisions of existing law relating to victims of sexual offenses if the specialty hospital has a policy for the transfer of a victim of a sexual assault to an appropriate hospital with an emergency department.

MO HEALTHNET HEARING AIDS (Section 208.152)

Currently, reimbursable MO HealthNet services include hearing aids for eligible needy children, pregnant women, and blind persons. The bill mandates MO HealthNet coverage of medically necessary cochlear implants and hearing instruments for all eligible participants.

PRENATAL TESTS FOR CERTAIN DISEASES (Section 210.030)

Currently, a physician or other health care provider must draw and test a pregnant woman's blood at or soon after her first prenatal examination, with her consent, for syphilis, hepatitis B, or other similar diseases. Under this bill, the testing of the pregnant woman's blood must also occur at the 28th week of her pregnancy as well as immediately after birth. Additionally, the test must include hepatitis C and HIV. If a mother tests positive for syphilis, hepatitis B, hepatitis C, or HIV, the physician or other health care provider will treat the mother in accordance with the most recent accepted medical practice.

Current law requires the Department of Health and Senior Services to work in consultation with the Missouri Genetic Disease Advisory Committee to make rules pertaining to these blood tests. The bill repeals the requirement to work with the Committee and requires that the tests be approved or accepted by the U.S. Food and Drug Administration.

EXAMINATION OF HEALTH MAINTENANCE ORGANIZATIONS (Section 354.465)

This bill repeals the requirement that the Department of Commerce and Insurance examine health maintenance organizations at least once every five years.

SELF-ADMINISTERED HORMONAL CONTRACEPTIVES COVERAGE (Section 376.1240)

Beginning January 1, 2026, this bill requires any health benefit plan in Missouri to reimburse a health care provider or dispensing entity for the dispensing of a supply of self-administered hormonal contraceptives intended to last up to one year. The bill prohibits the coverage from being subject to any greater deductible or copayment than other similar health care services provided by the health benefit plan.

CONTRACTS FOR HEALTH BENEFITS PROVIDED BY CERTAIN MEMBERSHIP ORGANIZATIONS (Section 376.1850)

This bill provides that statutes governing health insurance shall not apply to contracts for health care benefits provided by a qualified membership organization, as such terms are defined in the bill, to its members who have been members for at least 30 days, and that the qualified membership organization is not considered to be engaging in the business of insurance. Qualified membership organizations providing the contracts must register with the Department of Commerce and Insurance, as specified in the bill.

Contracts for health services under the bill must be sold, solicited, or negotiated only by insurance producers licensed to produce accident and health or sickness coverage. A qualified membership organization providing contracts, as specified in the bill, must use the services of a licensed third-party administrator, and agree in the contract with the administrator to be subject to certain processes for benefit determinations and claims payment procedures applicable to health carriers and health benefit plans as specified in the bill. Contracts for health care benefits are not subject to the insurance laws of the state except as provided in the bill.

Financial risk under the contracts may be reinsured as provided by law. The contracts and related applications and renewal forms must bear a disclaimer, as specified in the bill, to be signed by the organization member.

Contracts under the bill are not be subject to individual post-claim medical underwriting while coverage remains in effect, and members covered by the contracts are not subject to cancellation, nonrenewal, modification, or increase in premium for reason of a medical event.

The Division of Consumer Affairs within the Department of Commerce and Insurance must receive and review complaints and inquiries from members of qualified membership organizations, and qualified membership organizations providing contracts under the bill will annually pay a fee to the Department as provided in the bill.

The bill requires the qualified membership organizations to pay to the Department of Commerce and Insurance a fee equal to 1% of the Missouri claims paid under the contracts during the preceding year, prohibits the organizations from referring to or marketing the contracts as insurance, and requires the contracts to include certain coverage.

PRIOR AUTHORIZATION (Sections 376.2100, 376.2102, 376.2104, 376.2106, and 376.2108)

This bill provides that a health carrier or utilization review entity cannot require health care providers to obtain prior authorization for health care services, except under certain circumstances. Beginning January 1, 2026, prior authorization is not required unless a determination is made that less than 90% of prior authorization requests submitted by the health care provider in the previous evaluation period, as defined in the bill, were or would have been approved.

The bill establishes separate thresholds for requiring prior authorization for individual health care services or requiring prior authorization for all health care services.

Hospitals must meet one of three conditions for exemption:

(1) Enter into a value-based care agreement;

(2) Achieve a score of three or higher on the Center for Medicare and Medicaid Services Five-Star Quality Rating System; or

(3) Have at least 91% of prior authorization requests approved.

Critical access hospitals and those not participating in the Center for Medicare and Medicaid Services Five-Star system are automatically exempt from these conditions. Exemptions may be audited, up to a maximum of two times per year, and revoked under specific conditions, such as approval rates dropping below 90% or a significant increase in exempt procedures. Additionally, exemptions are void if providers are found guilty of fraud or abuse.

The exemption from prior authorization requirements will not include:

(1) Pharmacy services, not to exceed the amount of $100,000;

(2) Imaging services, not to exceed the amount of $100,000;

(3) Cosmetic procedures that are not medically necessary; or

(4) Investigative or experimental treatments.

The amounts for the pharmacy services and imaging services listed above will increased every year, rounded to the nearest thousand dollars, beginning January 1, 2027, based on the Consumer Price Index. Online portals may be required for prior authorization submissions. Patients with a new health plan receive a 90-day grace period for previously authorized medications.

The bill specifies requirements for notifying the provider of determinations in the bill, requires carriers and utilization review entities to maintain an online portal giving providers access to certain information, and provides that prior authorizations may be required beginning 25 business days after notice to the provider until the end of the evaluation period. Failure to notify providers of a determination as required in the bill will constitute prior authorization of the applicable health care services.

Lastly, no health carrier or utilization review entity can deny or reduce payments to a health care provider who had a prior authorization, unless the provider made a knowing and material misrepresentation with the intent to deceive the carrier or utilization review entity, or unless the health care service was not substantially performed.

This bill will not apply to Medicaid, except with regard to a Medicaid managed care organization as defined by law. The bill also does not apply to providers who have not participated in a health benefit plan offered by the carrier for at least one full evaluation period.

This bill should not be construed to authorize providers to provide services outside the scope of their licenses, nor to require health carriers or utilization review entities to pay for care provided outside the scope of a provider's license.

MAMMOGRAPHY (Section 192.679)

The bill repeals provisions relating to required notice provided to patients upon their completion of a mammogram.

The following is a summary of the public testimony from the committee hearing. The testimony was based on the Senate perfected version of the bill.

PROPONENTS: Supporters say that this bill attempts to strike a balance between coverage and affordability, and tries to be very clear about what may or may not be covered by these plans, what options are available, and the possibility to be denied coverage on account of a preexisting condition.

Testifying in person for the bill were Senator Gregory; Mo Soybean Association; Missouri Farm Bureau; Missouri Corn Growers Association; Missouri Speech-Language-Hearing Association; Missouri Center For Public Health Excellence; Mo Dairy; and Arnie C. Dienoff.

OPPONENTS: Those who oppose the bill say that the bill permits the state farm bureau to sell underregulated products that do not have to comply with consumer protections and other patient-minded regulations. As a result of consumers with preexisting conditions facing the possibility of denied coverage, they will be forced to return to marketplace insurance, which will impact the pool and its premium costs.

Testifying in person against the bill were American Heart Association; Emily Kalmar, American Cancer Society Cancer Action Network; National Multiple Sclerosis Society; and American Lung Association.

Written testimony has been submitted for this bill. The full written testimony and witnesses testifying online can be found under Testimony on the bill page on the House website.