

HOUSE _____ AMENDMENT NO. ____

Offered By

1 AMEND House Committee Substitute for Senate Substitute for Senate Committee Substitute for
2 Senate Bill No. 577, Page 2, Section A., by inserting after all of said section the following:
3 "103.003. As used in sections 103.003 to 103.175, the following terms mean:

4 (1) "Actuarial reserves", the necessary funding required to pay all the medical expenses
5 for services provided to members of the plan but for which the claims have not yet been received
6 by the claims administrator;

7 (2) "Actuary", a member of the American Academy of Actuaries or who is an enrolled
8 actuary under the Employee Retirement Income Security Act of 1974;

9 (3) "Agency", a state-sponsored institution of higher learning, political subdivision or
10 governmental entity or instrumentality;

11 (4) "Alternative delivery health care program", a plan of covered benefits that pays
12 medical expenses through an alternate mechanism rather than on a fee-for-service basis. This
13 includes, but is not limited to, health maintenance organizations and preferred provider
14 organizations, all of which shall include chiropractic physicians licensed under chapter 331,
15 RSMo, in the provider networks or organizations;

16 (5) "Board", the board of trustees of the Missouri consolidated health care plan;

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1 (6) "Claims administrator", an agency contracted to process medical claims submitted
2 from providers or members of the plan and their dependents;

3 (7) "Coordination of benefits", to work with another group-sponsored health care plan
4 which also covers a member of the plan to ensure that both plans pay their appropriate amount of
5 the health care expenses incurred by the member;

6 (8) "Covered benefits", a schedule of covered services, including chiropractic services,
7 which are payable under the plan;

8 (9) "Dental plan", any contractual arrangement to provide, either directly or through
9 arrangement with others, specified dental benefits to members on a fixed prepayment basis or as a
10 benefit of such subscribers' participation or membership in any other contract, agreement, or
11 group or any corporation, partnership, or other entity which undertakes to provide or arrange
12 specified dental benefits on a prepayment or other basis or to indemnify for specified dental
13 benefits;

14 [(9)] (10) "Employee", any person employed full time by the state or a participating
15 member agency, or a person eligible for coverage by a state-sponsored retirement system or a
16 retirement system sponsored by a participating member agency of the plan;

17 [(10)] (11) "Evidence of good health", medical information supplied by a potential
18 member of the plan that is reviewed to determine the financial risk the person represents to the
19 plan and the corresponding determination of whether or not he or she should be accepted into the
20 plan;

21 [(11)] (12) "Health care plan", any group medical benefit plan providing coverage on an
22 expense-incurred basis, any HMO, any group service or indemnity contract issued by a health plan
23 of any type or description;

24 [(12)] (13) "Medical benefits coverages" shall include services provided by chiropractic

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1 physicians as well as physicians licensed under chapter 334, RSMo;

2 [(13)] (14) "Medical expenses", costs for services performed by a provider and covered
3 under the plan;

4 (15) "Member", any person who is a participant in the Missouri consolidated health care
5 plan, including eligible subscribers and subscribers' spouses and unemancipated children;

6 [(14)] (16) "Missouri consolidated health care plan benefit fund account", the benefit trust
7 fund account containing all payroll deductions, payments, and income from all sources for the
8 plan;

9 [(15)] (17) "Officer", an elected official of the state of Missouri;

10 [(16)] (18) "Participating member agency", a state-sponsored institution of higher
11 learning, political subdivision or governmental entity that has elected to join the plan and has been
12 accepted by the board;

13 [(17)] (19) "Plan year", a twelve-month period designated by the board which is used to
14 calculate the annual rate categories and the appropriate coverage;

15 [(18)] (20) "Provider", a physician, hospital, pharmacist, psychologist, chiropractic
16 physician or other licensed practitioner who or which provides health care services within the
17 respective scope of practice of such practitioner pursuant to state law and regulation;

18 [(19)] (21) "Retiree", a person who is not an employee and is receiving or is entitled to
19 receive an annuity benefit from a state-sponsored retirement system or a retirement system of a
20 participating member agency of the plan or becomes eligible for retirement benefits because of
21 service with a participating member agency;

22 (22) "Subscriber", a person who is either:

23 (a) An eligible employee of the state or a participating member agency;

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- 1 (b) An eligible retiree of the state or a participating member agency;
2 (c) An eligible surviving spouse or dependent of a deceased employee or deceased
3 employee or deceased retiree of the state or a participating member agency;
4 (d) A former employee of the state or a participating member agency who is eligible for
5 coverage under the federal Consolidated Omnibus Budget Reconciliation Act; or
6 (e) A person eligible for medical assistance under section 208.146, RSMo, and not
7 otherwise eligible for coverage under the Missouri consolidated health care plan and who elects
8 dental or vision coverage or both through the Missouri consolidated health care plan;

9 (23) "Vision plan", any contractual arrangement to provide, either directly or through
10 arrangement with others, specified vision benefits to members on a fixed prepayment basis or as a
11 benefit of such subscribers' participation or membership in any other contract, agreement, or
12 group or any corporation, partnership, or other entity which undertakes to provide or arrange
13 specified vision benefits on a prepayment or other basis or to indemnify for specified vision
14 benefits.

15 103.005. For the purpose of covering medical, dental, and vision expenses of the officers,
16 employees and retirees, the eligible dependents of officers, employees and retirees and to the
17 surviving spouses and children of deceased officers, employees and retirees of the state and
18 participating member agencies of the state, and providing dental and vision benefits to eligible
19 participants of medical assistance under section 208.146, RSMo, there is hereby created and
20 established a health care plan which shall be a body corporate, which shall be under the
21 management of the board of trustees herein described, and shall be known as the "Missouri
22 Consolidated Health Care Plan". Notwithstanding any provision of law to the contrary, such plan
23 may sue and be sued, transact business, contract, invest funds and hold cash, securities and other
24 property and shall be vested with such other powers as may be necessary or proper to enable it, its

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1 officers, employees, and agents to carry out fully and effectively all the purposes of sections
2 103.003 to 103.175.

3 103.087. For purposes of this section, the terms "medical assistance subscriber" or
4 "medical assistance participant" shall mean a person receiving medical assistance under section
5 208.146, RSMo. Except as otherwise provided by sections 103.003 to 103.175, dental and vision
6 benefits coverage as provided by sections 103.003 to 103.175 shall be made available to persons
7 receiving medical assistance under section 208.146, RSMo. Spouses or unemancipated children
8 under the age of twenty-three of such persons shall also be eligible to receive such dental and
9 vision benefits.

10 (1) Dental and vision plans shall be available for enrollment by medical assistance eligible
11 participants no earlier than January 1, 2008, and no later than July 1, 2008;

12 (2) The cost of providing dental and vision benefits to medical assistance eligible
13 subscribers and subscribers' dependents not otherwise eligible for coverage through the Missouri
14 consolidated health care plan shall not be allowed to adversely affect the state's or participating
15 member agencies' rates or benefits;

16 (3) An initial thirty-day enrollment period shall be available for persons eligible for
17 medical assistance not otherwise eligible for coverage under the Missouri consolidated health care
18 plan to enroll in the dental or vision benefits or both under the Missouri consolidated health care
19 plan. This initial thirty-day enrollment period shall begin from such person's initial date of
20 approval under medical assistance under section 208.146, RSMo;

21 (4) There shall be an annual thirty-day enrollment period, at a time designated by the
22 board, during which persons eligible for medical assistance not otherwise eligible for coverage
23 under the Missouri consolidated health care plan shall be able to enroll in the dental or vision
24 plans or both;

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1 (5) Medical assistance participants not otherwise eligible for coverage under the Missouri
2 consolidated health care plan shall also be eligible to enroll in the dental or vision plans or both as
3 a medical assistance participant within sixty days of a loss of other group dental or vision
4 coverage, or both, provided that such coverage was in place for at least twelve consecutive months
5 immediately prior to the loss and that such loss was due to:

6 (a) The subscriber's or the subscriber's spouse's termination of employment; or

7 (b) Termination of group dental or vision coverage, or both, by the employer;

8 (6) Coverage for such dental and vision benefits to medical assistance subscribers and
9 subscribers' dependents shall terminate when the medical assistance participant ceases to be
10 eligible for medical assistance;

11 (7) Monthly, in accordance with a schedule developed by the board, or its designee, the
12 medical assistance subscriber shall promptly pay to the executive director an amount equal to the
13 amount of the premium due based upon the participation in the dental or vision plans, or both, as
14 billed by the Missouri consolidated health care plan. Such premium shall be set by the board and
15 shall cover all associated costs, including administrative costs, of the plan for providing such
16 services to medical assistance participants. The executive director shall promptly deposit such
17 amounts to the benefit trust fund account;

18 (8) The plan shall not assume responsibility for any liabilities incurred by the medical
19 assistance program or its eligible participants or its participants' spouses or unemancipated
20 dependents prior to the group's effective date;

21 (9) If so determined by the board, the department of social services shall reimburse the
22 plan for any initial start-up costs incurred by the plan solely on behalf of the medical assistance
23 participants and necessary in order for the medical assistance participants to be included in the
24 plan;

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1 (10) If a medical assistance subscriber fails to make any payment due the plan, the board
2 may immediately terminate the medical assistance subscriber's and associated members'
3 enrollment in the plan and stop paying claims accrued during the period of nonpayment. Any
4 subscriber terminated for non-payment of premiums shall not be eligible for coverage until the
5 next annual enrollment period as provided in subdivision (4) of this section.”; and

6
7 Further amend said bill, Page 26, Section 208.146, Lines 1 to 62, by deleting all of said lines and
8 inserting in lieu thereof the following:

9 “208.146. 1. The program established under this section shall be known as the "Ticket to
10 Work Health Assurance Program". Subject to appropriations and in accordance with the federal
11 Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), Public Law 106-170,
12 the medical assistance provided for in section 208.151 may be paid for a person who is employed
13 and who:

14 (1) Except for earnings, meets the definition of disabled under the Supplemental Security
15 Income Program or meets the definition of an employed individual with a medically improved
16 disability under TWWIIA;

17 (2) Has earned income, as defined in subsection 2 of this section;

18 (3) Meets the asset limits in subsection 3 of this section;

19 (4) Has net income, as defined in subsection 3 of this section, that does not exceed the
20 limit for permanent and totally disabled individuals to receive nonspenddown MO HealthNet
21 under subdivision (24) of subsection 1 of section 208.151; and

22 (5) Has a gross income of two hundred fifty percent or less of the federal poverty level,
23 excluding any earned income of the worker with a disability between two hundred fifty and three
24 hundred fifty percent of the federal poverty level. For purposes of this subdivision, "gross

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1 income" includes all income of the person and the person's spouse that would be considered in
2 determining MO HealthNet eligibility for permanent and totally disabled individuals under
3 subdivision (24) of subsection 1 of section 208.151. Individuals with gross incomes in excess of
4 one hundred percent of the federal poverty level shall pay a premium for participation in
5 accordance with subsection 4 of this section.

6 2. For income to be considered earned income for purposes of this section, the department
7 of social services shall document that Medicare and Social Security taxes are withheld from such
8 income. Self-employed persons shall provide proof of payment of Medicare and Social Security
9 taxes for income to be considered earned.

10 3. (1) For purposes of determining eligibility under this section, the available asset limit
11 and the definition of available assets shall be the same as those used to determine MO HealthNet
12 eligibility for permanent and totally disabled individuals under subdivision (24) of subsection 1 of
13 section 208.151 except for:

14 (a) Medical savings accounts limited to deposits of earned income and earnings on such
15 income while a participant in the program created under this section with a value not to exceed
16 five thousand dollars per year; and

17 (b) Independent living accounts limited to deposits of earned income and earnings on such
18 income while a participant in the program created under this section with a value not to exceed
19 five thousand dollars per year. For purposes of this section, an "independent living account"
20 means an account established and maintained to provide savings for transportation, housing, home
21 modification, and personal care services and assistive devices associated with such person's
22 disability.

23 (2) To determine net income, the following shall be disregarded:

24 (a) All earned income of the disabled worker;

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- 1 (b) The first sixty-five dollars and one-half of the remaining earned income of a
2 nondisabled spouse's earned income;
3 (c) A twenty-dollar standard deduction;
4 (d) Health insurance premiums;
5 (e) A seventy-five dollar a month standard deduction for the disabled worker's dental and
6 optical insurance when the total dental and optical insurance premiums are less than seventy-five
7 dollars;
8 (f) All Supplemental Security Income payments, and the first fifty dollars of SSDI
9 payments;
10 (g) A standard deduction for impairment-related employment expenses equal to one-half
11 of the disabled worker's earned income.

12 4. Any person whose gross income exceeds one hundred percent of the federal poverty
13 level shall pay a premium for participation in the medical assistance provided in this section.
14 Such premium shall be:

15 (1) For a person whose gross income is more than one hundred percent but less than one
16 hundred fifty percent of the federal poverty level, four percent of income at one hundred percent
17 of the federal poverty level;

18 (2) For a person whose gross income equals or exceeds one hundred fifty percent but is
19 less than two hundred percent of the federal poverty level, four percent of income at one hundred
20 fifty percent of the federal poverty level;

21 (3) For a person whose gross income equals or exceeds two hundred percent but less than
22 two hundred fifty percent of the federal poverty level, five percent of income at two hundred
23 percent of the federal poverty level;

24 (4) For a person whose gross income equals or exceeds two hundred fifty percent but less

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1 than three hundred percent of the federal poverty level, six percent of income at two hundred fifty
2 percent of the federal poverty level;

3 (5) For a person whose gross income equals or exceeds three hundred percent but less
4 than three hundred fifty percent of the federal poverty level, seven percent of income at three
5 hundred percent of the federal poverty level.

6 5. Recipients of services through this program shall report any change in income or
7 household size within ten days of the occurrence of such change. An increase in premiums
8 resulting from a reported change in income or household size shall be effective with the next
9 premium invoice that is mailed to a person after due process requirements have been met. A
10 decrease in premiums shall be effective the first day of the month immediately following the
11 month in which the change is reported.

12 6. If an eligible person's employer offers employer-sponsored health insurance and the
13 department of social services determines that it is more cost effective, such person shall
14 participate in the employer-sponsored insurance. The department shall pay such person's portion
15 of the premiums, co-payments, and any other costs associated with participation in the employer-
16 sponsored health insurance.

17 7. Those persons found eligible for medical assistance through this section shall have the
18 right to purchase dental or optical insurance or both through the Missouri Consolidated Health
19 Care Plan.”; and

20
21 Further amend said bill, page 60 and 61, Section 208.640, Lines 1 to 41, by deleting all of said
22 lines and inserting in lieu thereof the following:

23 “208.640. 1. Parents and guardians of uninsured children with incomes [between] above one
24 hundred [fifty-one and] fifty percent and below three hundred percent of the federal poverty level

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1 who do not have access to affordable employer-sponsored health care insurance or other
2 affordable health care coverage may obtain coverage pursuant to this section.

3 2. For families with gross income above one hundred fifty percent to one hundred eighty-
4 five percent of the federal poverty level for the purposes of sections 208.631 to 208.657,
5 "affordable employer-sponsored health care insurance or other affordable health care coverage"
6 refers to health insurance requiring a monthly premium of three percent of one hundred fifty
7 percent of the federal poverty level for a family of three [less than or equal to one hundred thirty-
8 three percent of the monthly average premium required in the state's current Missouri consolidated
9 health care plan]. For families with gross income above one hundred eighty-five percent to two
10 hundred twenty-five percent of the federal poverty level for the purposes of sections 208.631 to
11 208.657, "affordable employer-sponsored health care insurance or other affordable health care
12 coverage" refers to health insurance requiring a monthly premium of four percent of one hundred
13 eighty-five percent of the federal poverty level for a family of three. For families with gross
14 income above two hundred twenty-five percent and below three hundred percent of the federal
15 poverty level for the purposes of sections 208.631 to 208.657, "affordable employer-sponsored
16 health care insurance or other affordable health care coverage" refers to health insurance requiring
17 a monthly premium of five percent of two hundred twenty-five percent of the federal poverty level
18 for a family of three. Health insurance plans that do not cover an eligible child's pre-existing
19 condition shall not be considered "affordable employer-sponsored health care insurance or other
20 affordable health care coverage" for purposes of sections 208.631 to 208.657.

21 3. The parents and guardians of eligible uninsured children pursuant to this section are
22 responsible for a monthly premium [equal to the average premium required for the Missouri
23 consolidated health care plan] as required by annual state appropriation; provided that the total
24 aggregate cost sharing for a family covered by these sections shall not exceed five percent of such

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1 family's income for the years involved. No co-payments or other cost sharing is permitted with
2 respect to benefits for well-baby and well-child care including age-appropriate immunizations.
3 Cost-sharing provisions pursuant to sections 208.631 to 208.657 shall not exceed the limits
4 established by 42 U.S.C. Section 1397cc(e).

5 208.658. Up to one percent of any federal funds received under the provisions of Title
6 XXI of the Social Security Act, as amended, and up to one percent of any state funds used to
7 match those federal funds may be used for outreach through the MO HealthNet division for
8 children's health program established under sections 208.631 to 208.657. The MO HealthNet
9 division may contract with local public health agencies for purposes of this section. The
10 provisions of this section shall be subject to appropriation.”; and

11
12 Further amend said bill, Page 64, Section 208.696, Line 19, by deleting the word “and”; and

13
14 Further amend said bill, Page 64, Section 208.696, Line 20, by inserting immediately following
15 the word “care”; the following “partnership approved”; and

16
17 Further amend said bill, page 65, Section 208.696, Lines 23 to 24 by deleting all of said lines and
18 inserting in lieu thereof the following:

19 “eligibility;
20 (7) Develop requirements that all long-term care policies sold in the state of Missouri shall
21 include coverage for all home and community based services, including but not limited to
22 consumer-directed services, in-home, home health, and assisted living services;

23 (8) Develop requirements that all long-term care insurance policies sold in the state of Missouri
24 shall disallow exclusions based on pre-existing conditions;

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1 (9) Develop requirements that vendors of long-term care policies shall not charge a higher fee for
2 premiums for individuals with pre-existing conditions or disabilities; and
3 (10) Develop requirements that all vendors of long-term care insurance shall provide each
4 potential purchaser with accurate and verifiable information on the rates, expressed as a
5 percentage of all claims for long-term care services which the vendor has denied in the past
6 twelve months”; and

7
8 Further amend said bill, page 103, Section 4, by inserting after all of said section the following:
9 “Section 5. The provisions in section 103.005, RSMo, relating to dental and vision benefits for
10 medical assistance participants under section 208.146, RSMo, section 103.087, RSMo, section
11 208.146, RSMo, and subsection 7 of section 208.151, RSMo, shall expire six years after the
12 effective date of this act.”; and

13
14 Further amend said bill, page 107, Section B., by inserting after all of said section the following:
15 “Section C. The repeal and reenactment of sections 103.003, 103.005, and 208.151, and the
16 enactment of sections 103.087 and 208.146, shall be effective upon notice to the revisor of
17 statutes that a waiver or approval of a state plan amendment has been obtained from the Secretary
18 of the Department of Health and Human Services by the director of the department of social
19 services.”; and

20
21 Further amend said bill by amending the title, enacting clause, and intersectional references
22 accordingly.

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