HCS HB 700 -- SHOW-ME TRANSFORMATION ACT

SPONSOR: Barnes

COMMITTEE ACTION: Voted "Do Pass" by the Committee on Government Oversight and Accountability by a vote of 7 to 2.

This substitute establishes the Show-Me Transformation Act and changes the laws regarding the Ticket to Work Health Assurance Program and the MO HealthNet Program. In its main provisions, the substitute:

(1) Extends the provisions regarding the Ticket to Work Health Assurance Program from August 28, 2013, to July 1, 2014.

(2) Specifies that effective August 28, 2013, MO HealthNet benefits are provided to any person who is in foster care under the responsibility of the State of Missouri on the date he or she turns 18 years old or at any time during the 30-day period preceding his or her 18th birthday, without regard to income or assets if the person is younger than 26 years of age, is not eligible for coverage under another mandatory coverage group, and was covered by the Missouri Medicaid Program while he or she was in foster care;

(3) Specifies that beginning July 1, 2014:

(a) Any person receiving blind pension benefits will no longer be eligible for MO HealthNet benefits;

(b) Any person deemed eligible due to a diagnosis of breast or cervical cancer will no longer be eligible for MO HealthNet benefits unless the individual does not have access to employer-sponsored health insurance coverage or subsidized insurance coverage through an exchange at any point after diagnosis and the individual’s income is between 100% and 200% of the federal poverty level (FPL);

(c) Coverage of pregnant women whose income is between 133% and 185% of the FPL must be in the form of a premium subsidy as established by department rule in order for them to enroll in a health insurance plan offered by a health care exchange. The women must be directed to choose an exchange plan and will be eligible for a premium subsidy equal to the amount of the percentage of income required for premium payments or coinsurance by federal rule; and

(d) Limits, beginning October 1, 2019, the eligibility of infants under one year of age to those infants whose family income does not exceed 185% of the FPL. Infants under one year of age born to

women covered under the above subsection c with a family income between 133% and 185% of the FPL must only be eligible if, in addition to other requirements, the infant's parents do not have access to health insurance coverage for the child through a health insurance plan in a health care exchange and the parents are not eligible for a premium subsidy for the child or family through an exchange because the parents are determined to have access to affordable health insurance;

(4) Prohibits any of the changes in subsection (3) from occurring unless and until:

(a) There are federal health insurance premium tax credits 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. The Director of the Department of Revenue must certify to the Director of the Department of Social Services that health insurance premium tax credits are available, and the Director of the Department of Social Services must notify the Revisor of Statutes;

(b) The federal Department of Health and Human Services has approved eligibility of specified populations, the Department of Social Services has implemented eligibility for the population, 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 these provisions, federal funding is received for the premium subsidies to be paid, and notice has been provided to the Revisor of Statutes;

(5) Requires the Department of Social Services to 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 federal premium tax credits available through the purchase of a health insurance plan in a health care exchange and the benefits that would be potentially covered under the insurance;

(6) Requires any MO HealthNet participant 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 commission of the crime to 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;

(7) Requires a MO HealthNet Program participant who is a parent of a child subject to proceedings in juvenile court because the child is alleged to be in need of care and treatment under 211.031, RSMo, whose misuse of controlled substances or alcohol is found to be a significant, contributing factor to the reason the child was adjudicated, must 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 must be included in the child's permanency plan, and the court may order the parent or guardian to successfully complete treatment before the child is reunified with the parent or guardian;

(8) Requires, if requested by the court, the MO HealthNet Division in the Department of Social Services to certify a MO HealthNet participant's enrollment in MO HealthNet. A letter signed by the division director or his or her designee, or the Family Support Division in the department certifying that the individual is a participant in the program must be prima facie evidence of the participation and must 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;

(9) Specifies that beginning October 1, 2019, a child eligible for the current Children's Health Insurance Plan (CHIP) must only remain eligible if, in addition to 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 because the parents are not eligible for a premium subsidy for the child or family through the exchange. This change cannot go into effect unless and until federal health insurance premium tax credits are available for children and family coverage to purchase a health insurance plan from a health care exchange and the credits are available for six months prior to the discontinuation of CHIP benefits. The department must inform participants of the possibility of insurance coverage via the purchase of a subsidized health insurance plan available through a health care exchange six months before CHIP coverage is discontinued;

(10) Specifies that beginning July 1, 2014, the Uninsured Women's Health Program will no longer be in effect. The change in eligibility will not take place unless and until for a six-month period preceding the discontinuance of benefits, there are federal health insurance premium tax credits available for children and family coverage through the purchase a health insurance plan in a health care exchange and eligibility for the MO HealthNet

alternative package has received any necessary approvals from the federal Department of Health and Human Services, the alternative package has been implemented by the department, and notice has been provided to the Missouri Revisor of Statutes. The department must inform participants of the possibility of insurance coverage via the purchase of a subsidized health insurance plan through a health care exchange six months before coverage is discontinued;

(11) Requires the department to 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 50% or more students who are eligible for free or reduced-price lunch. Any school-based health care clinic is prohibited from performing or referring for abortion services or providing or referring for contraceptive drugs or devices. The consent of a parent or guardian must be required before a minor can receive health care services from a school-based health care clinic. These provisions will be null and void unless and until any necessary waivers are granted by the federal government;

(12) Establishes the Show-Me Healthy Babies Program within the Department of Social Services as a separate CHIP Program 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. The program must 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. To enroll, an unborn child's mother must not be eligible for coverage under Title XIX of the federal Social Security Act or the Medicaid Program as it is administered by the state and must not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. Coverage for an unborn child must 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 department regulations. Services that are solely beneficial to the mother that are unrelated to maintaining or promoting a health pregnancy and that do not benefit the unborn child must not be covered. There must not be a waiting period for the enrollment of an unborn child. Coverage for the child must continue for up to one year after birth unless otherwise limited by the General Assembly through appropriations. Pregnancy-related and postpartum coverage for the mother must 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 otherwise

limited by the General Assembly through appropriations. These provisions cannot be construed to prohibit an unborn child from enrollment in the program at the same time that his or her mother is enrolled in MO HealthNet, CHIP, Medicare, or other governmental or government-subsidized health care program. The department must ensure that there is no duplication of payments from the program for services that are payable under a governmental or nongovernmental health care program for services to an eligible pregnant woman. The department may provide coverage for an unborn child through direct coverage where the state pays health care providers directly or by contracting with a managed care organization or health insurance provider; through a premium assistance program through a combination of direct coverage and premium assistance; or through any similar arrangement where costs are lower without sacrificing health care coverage for the child, there are greater covered services for the child, there is a similar cost for coverage of the child and coverage for siblings or other family will also be provided, or there will be an ability for the child to transition more easily to less government-subsidized or nongovernmental coverage after the child is no longer enrolled in the program. The department must provide information about the program to maternity homes, pregnancy resource centers, and other similar agencies and programs in the state that assist unborn children and their mothers. Within 60 days after the effective date of these provisions, the department must submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the program. At least annually, the department must prepare and submit a report to the Governor, Speaker of the House of Representatives, and 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 program. The substitute specifies the information that must be included in the report. The program cannot be deemed an entitlement program, but instead must be subject to a federal allotment or other federal appropriations and matching state appropriations. These provisions cannot be construed as obligating the state to continue the 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. These provisions cannot be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state;

(13) Specifies that in order to be eligible for MO HealthNet benefits an individual must be a resident of the State of Missouri; have a valid Social Security number; be a citizen of the United States or a qualified alien with satisfactory documentary evidence

of qualified alien status that has been verified by the federal Department of Homeland Security; and if claiming eligibility as a pregnant woman, she must verify the pregnancy;

(14) Requires, effective January 1, 2014, the Family Support Division within the Department of Social Services to conduct an annual redetermination of all MO HealthNet participants' eligibility and permits the department to contract with an administrative service organization to conduct the annual redeterminations if it is cost effective;

(15) Requires the department or the Family Support Division to conduct electronic searches to redetermine eligibility on the basis of income, residency, citizenship, identity, and other criteria upon availability of federal, state, and commercially available electronic data sources. The department or division may enter into a contract with a vendor to perform the electronic searches of eligibility information not disclosed during the application process and obtain an applicable case management system. The department must retain final authority over eligibility determinations made during the redetermination process;

(16) Requires an individual who is applying for MO HealthNet benefits to submit an application in accordance with federal law, including 42 CFR 435.907, and to provide all required information and documentation necessary to make an eligibility determination, resolve discrepancies found during the redetermination process, or for any purpose directly connected to the administration of the medical assistance program;

(17) Requires the department to determine an individual's financial eligibility based on projected annual household income and family size for the remainder of the current year; to determine the modified adjusted gross household by including all actually available cash support provided by the person claiming the applying individual as a dependent for tax purposes; and to determine a pregnant woman's household size by counting the pregnant woman plus the number of children she is expected to deliver. A CHIP-eligible child must be uninsured and not have access to affordable insurance, and the child's parent must pay the required premium. An individual claiming eligibility as an uninsured woman must be uninsured;

(18) Prohibits the MO HealthNet Program from providing coverage to a parent or other caretaker relative living with a dependent child who is classified as medically frail unless the child is receiving benefits under MO HealthNet or CHIP or is enrolled in minimum essential coverage;

(19) Specifies that the provisions of the act will be null and void unless:

(a) There are health insurance premium tax credits available to persons through the purchase of a health insurance plan in a health care exchange;

(b) Eligibility for the alternative package population has been approved by the federal Department of Health and Human Services and has been implemented by the Department of Social Services;

(c) The federal department grants the required waivers, state plan amendments, and enhanced federal funding rate for persons newly eligible for the alternative package and the alternative package enhanced federal funding rates are granted by the federal government; and

(d) The federal funds at the disposal of the state at any time is not at least 90% of the funds necessary or are not appropriated to pay the promised enhanced matching rates under Section 2001 of Public Law 111-48 as it existed on March 23, 2010;

(20) Specifies that the provisions of subsection (19) do not apply to the MO HealthNet Transformation Task Force, the expanded coverage of foster care children, the requirements under subsections (13) through (17), and the income conversion;

(21) Requires, as MO HealthNet or other expenditures are reduced or savings are achieved as a result of the substitute, the portion of the state share of those expenditures funded by provider taxes described in 42 CFR 433.56 to be credited or otherwise accrued to the depository account where the proceeds of the tax are deposited;

(22) Specifies that effective January 1, 2014, those eligible for MO HealthNet benefits must include:

(a) Individuals covered by MO HealthNet for families under Section 208.145;

(b) Individuals covered by transitional MO HealthNet under 42 U.S.C. Section 1396r-6;

(c) Individuals covered by extended MO HealthNet for families on child support closings under 42 U.S.C. Section 1396r-6;

(d) Pregnant women who meet the requirements for aid to families with dependent children benefits except for the existence of a dependent child in the home; pregnant women who meet the requirements for aid to families with dependent children except for

the existence of a dependent child who is deprived of parental support; and pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to 133% of the FPL;

(e) Children between the ages of one year old and six years old who are eligible for medical assistance and whose family income does not exceed an income eligibility standard equal to 133% of the FPL;

(f) Children between the ages of six years old and 19 years old whose family income is equal to or less than equal to 100% of the FPL;

(g) CHIP-eligible children; and

(h) Uninsured women under Section 208.659;

(23) Specifies that eligibility for those listed in subsection (22) must be determined by the department by converting applicable income standards to the individual's modified adjusted gross income (MAGI) equivalent net income standard;

(24) Specifies that effective January 1, 2014, and subject to the receipt of all appropriate waivers and approval of state plan amendments, individuals who meet the following qualifications must be eligible for the alternative package of MO HealthNet benefits:

(a) Are 19 years of age or older and younger than 65 years of age;

(b) Are not pregnant;

(c) Are not entitled to or enrolled for federal Medicare benefits;

(d) Are not otherwise eligible for and enrolled for mandatory MO HealthNet Program coverage; and

(e) Have a household income that is at or below 100% of the FPL for the applicable family size for the applicable year under the MAGI equivalent net income standard;

(25) Requires the department to immediately seek any waivers necessary to implement these provisions. The waivers must promote healthy behavior and include no co-payment for preventive care, require personal responsibility in the payment of health care by establishing appropriate co-payments based on family income that will discourage the use of emergency room visits for non-emergent care and promote responsible use of other health care services, promote the adoption of healthier personal habits, allow recipients

to receive an annual cash incentive to promote responsible behavior and encourage efficient use of health care services, allow health plans to offer a health savings account option, allow health plans to offer a health savings account option, and include a request for an enhanced federal funding rate for newly eligible participants. If the waivers and enhanced federal funding rates are not granted, these provisions must be null and void.

(26) Requires the division to establish 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 the limitations as established in division regulations;

(27) Requires the department to provide premium subsidy and other cost supports for individuals eligible for MO HealthNet benefits to enroll in employer-provided health plans or other private health plans based on cost-effective principles determined by the department. All individuals who meet the definition of medically frail must receive all benefits that they are eligible to receive under Sections 208.152, 208.900, 208.903, 208.909, and 208.930. The Department of Social Services, in conjunction with the Department of Mental Health and the Department of Health and Human Services, must establish a screening process for determining whether an individual is medically frail and must enroll all eligible individuals who are deemed medically frail and whose care management would benefit from being assigned a health home in health home program or other care coordination as established by the Department of Social Services. However, any eligible individual may opt out of the health home program;

(28) Requires the division to 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 program must provide payment to primary care clinics for care coordination for individuals deemed medically frail. Clinics must meet certain specified criteria, including the capacity to develop care plans; a dedicated care coordinator; an adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement; and the capability to maintain and use a disease registry. A primary care clinic must include a community health care center. The health care home for recipients of MO HealthNet services with an adjudicated level of care of 21 points or greater as determined by the screening process under state rules and regulations or those deemed eligible for skilled nursing facility placement but who are not currently residing in a nursing facility, must be the primary provider of home- and community-based services for the recipient if the provider has a qualified licensed designee to serve as the

recipient's care coordinator and the provider can demonstrate the ability to meet all primary care clinic and health care home requirements. Providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems and screening and brief intervention must be reimbursed for utilizing the behavior assessment and intervention, and screening and brief intervention reimbursement codes 96150 to 96155 and 99408 to 99409 under the Current Procedural Terminology coding system. Location of service may be limited to NCQA Level 3 Patient-Centered Medical Homes and CARF-accredited health homes. 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. These provisions must be implemented in a way that it does not conflict with federal requirements for health care home participation by MO HealthNet Program recipients;

(29) Requires, except for those individuals deemed medically frail, recipients of the alternative package of MO HealthNet benefits to receive covered services through health plans offered by managed care entities authorized by the department. The health plans must resemble commercially available health plans while complying with federal Medicaid Program 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; must promote, to the greatest extent possible, the opportunity for children and their parents to be covered under the same plan; must offer plans statewide; must include cost sharing for out patient services to the maximum extent allowed by federal law; may include other co-payments and provide incentives that encourage and reward the prudent use of the health benefit provided; must encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates; must provide incentives, including shared risk and savings, to health plans and providers to encourage cost-effective delivery of care; may provide multiple plan options and reward participants for choosing a low-cost plan; and must include the services of health providers as required by federal law and must meet the payment requirements for the health providers as required by federal law. The department may designate that certain health care services be excluded from the health plans if it is determined cost effective by the department. The department may accept regional plan proposals as an additional option for beneficiaries. The proposals may be submitted by accountable care organizations or other organizations and entities. The department must advance the development of systems of care for medically complex children who

are MO HealthNet benefit recipients 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. The entities must be treated as accountable care organizations. The department, in collaboration with plans and providers, must establish uniform utilization review protocols to be used by all authorized health plans;

(30) Requires the department to establish a competitive bidding process for contracting with managed care plans. The substitute requires:

(a) The department to 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 the state.

(b) The bidder, if the bidder offers an identical or similar plan, in services provided or network, or the bidder and the associated company, if the bidder has formed a partnership for purposes of its bid, to include a process in its bid to allow MO HealthNet recipients who choose its plan to be automatically enrolled in the corresponding exchange plan if the recipient's income increases resulting in his or her ineligibility for MO HealthNet benefits. The bidder must also include in its bid a process to allow an individual enrolled in an identical or substantially similar exchange plan in the state to, in the event his or her income decreases resulting in eligibility for MO HealthNet, to be enrolled in MO HelathNet after an application is received and the applicant is deemed eligible;

(c) The department to select a minimum of three winning bids and may select up to a maximum number of bids equal to the number of anticipated participants in a region by 100,000;

(d) The department to accept the lowest conforming bid.

(e) The department to consider, in determining other accepted bids, the cost to Missouri taxpayers, the extent of the network of health care providers offering services within the bidder's plan, additional services offered to recipients under the bidder's plan, the bidder's history of providing managed care plans for similar populations in Missouri or other states, and any other criteria that the department deems relevant to ensure MO HealthNet benefits are provided to recipients in a way that saves taxpayer money and improves the health outcomes of recipients; and

(f) Any managed care organization that enters into a contract with the state to provide managed care plans to be required to fulfill the terms of the contract and provide the plans for at least 12 months or longer if provided in the contract. The state must not increase the reimbursement rate provided to the managed care organization during the contract period above the rate included in the contract. If the organization breaches the contract, the state must be entitled to bring an action against the organization for any remedy allowed by law or equity and must also recover any and all damages provided by law, including liquidated damages in an amount determined by the department during the bidding process. These provisions cannot be construed to preclude the department or the state 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;

(31) Requires any participant enrolling in a managed care plan to have the ability to choose his or her plan. In the enrollment process, a participant must be provided a list of all plans available ranked by the relative actuarial value of each plan and each participant must be informed that he or she will be eligible to receive a portion of the amount saved my Missouri taxpayers if he or she chooses a lower cost plan offered in his or her region. The amount received will be determined by the department according to the department's best judgment as to the portion that will bring the maximum savings to Missouri taxpayers. If a participant fails or refuses to select a plan, the department must determine rules for auto-assignment that must include incentives for low-cost bids and improved health outcomes as determined by the department. These provisions cannot be construed to require the department to terminate any existing managed care contract or to extend any managed care contract;

(32) Requires all MO HealthNet managed care plans to provide coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse treatment, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness care, and chronic disease management; pediatric services, including oral and vision care; and any other services required by federal law. No MO HealthNet plan or program may 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;

(33) Requires the MO HealthNet Program to provide a high-deductible health plan option for uninsured adults 19 years of

age or older and younger than 65 years of age with an income of less than 100% of the FPL. The plan must include coverage for benefits as specified by department rule after meeting a $1,000 deductible an account, funded by the department, of at least $1,000 per adult to pay the medical costs for the initial deductible; preventative care, as defined by department rule, that is not subject to the deductible and does not require a payment of money from the account; a basic benefits package if annual medical costs exceed $1,000; and a minimum deductible of $1,000. As soon as practicable, the health plan must establish and maintain a record keeping system for each health care visit or service received by recipients. The plan must require that the recipient's prepaid card number be entered or the electronic strip must be swiped by the health care provider for every health care visit or service received by the recipient regardless of the balance on the card. The information may only include the date of service, the name of the provider, and a general description of the visit or service provided. The plan must keep a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped. If necessary under state or federal law, a recipient must be required to provide a written waiver for disclosure of this information as a condition of participation in the prepaid card incentive. The department must determine the proportion of the amount left in a participant's account that must be paid to the participant for saving taxpayer money and the method of payment. The department must determine the proportion of a participant's account that must be used to subsidize premiums to facilitate a participant's transition from health coverage under MO HealthNet to private insurance based on cost-effective principles determined by the department;

(34) Requires all participants with chronic conditions, as specified by the department, to be included in an incentive program for MO HealthNet recipients who obtain specified primary care and preventive services and who participate or refrain from specified activities to improve the recipient's overall health. Those recipients who successfully complete the requirements of the program are eligible to receive an annual cash payment. The department must establish by rule the specific primary care and preventive services and activities to be included in the program and the amount of any annual cash payments;

(35) Specifies that a MO HealthNet recipient is eligible to participate in only one of either the high deductible health plan or the incentive program for chronic conditions. No cash payments, incentives, or credits paid to or on behalf of a participant under a MO HealthNet Program are to be considered income in any means-tested benefit program unless otherwise required by law or department rule;

(36) Requires managed care entities to inform a participant who chooses the high-deductible health plan that the participant may lose his or her incentive payment if he or she utilizes emergency services for non-emergent purposes and requires the information to be included on every electronic and paper correspondence between the managed care plan and the participant;

(37) Requires the department to seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services that are necessary to implement the provisions of the substitute. No provisions of the substitute may be implemented unless the waivers and state plan amendments are approved;

(38) Requires, subject to appropriations, the department to develop incentive programs to encourage the construction and operation of urgent care clinics that operate outside normal business hours and are located in or adjoined to emergency room facilities that receive a high proportion of patients who are participating in MO HealthNet to the extent that the incentives are eligible for federal matching funds;

(39) Specifies that beginning August 28, 2013, the Board of Directors of the Missouri Health Insurance Pool, the executive director, and any other employees of the pool must 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. This authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange. On or before September 1, 2013, the board must submit the 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. The amendments to the plan of operation submitted by the board must include all current requirements under Section 376.962.2, including the selection of an administering insurer or third-party administrator, and must 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 must also address procedures for finalizing the financial matters of the pool, including assessments, claims expenses, and other specified matters. The Director of the Department of Insurance, Financial Institutions and Professional Registration must review the plan of operation and must establish rules to effectuate the transitional plan of operation. The rules must be effective no later than October 1, 2013;

(40) Specifies that prior to January 1, 2014, the board of directors of the pool and administering insurers may issue policies of insurance from the Missouri Health Insurance Pool; however, they are prohibited from issuing new insurance policies on or after January 1, 2014. All coverage under the pool must expire on January 1, 2014;

(41) Requires, on or before September 1, 2013, the board of the pool to 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 must be made prior to January 1, 2014. Beginning January 1, 2014, the administering insurer or third-party administrator must:

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

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

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including making available information relating to the proper manner of submitting a claim for benefits to the pool, distributing forms upon which submission must be made, and evaluating the eligibility of each claim for payment by the pool;

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

(e) Determine, following the close of each calendar year, the expense of administration and the paid and incurred losses for the year and report the information to the board and department on a form prescribed by the department director; and

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

(42) Requires Missouri Health Insurance Pool assessments to continue until the executive director of the pool provides notice to the board and the department director that all claims have been paid. Any assessment funds remaining at the time the executive director provides notice that all claims have been paid must be deposited in the General Revenue Fund; and

(43) Specifies that 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 will be eligible for a private insurance premium subsidy to assist the recipient in paying the costs of the private insurance if it determined to be cost effective by the department. The subsidy must 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;

(44) Establishes the 16-member MO HealthNet Transformation Task Force in the Department of Social Services. The members are as follows:

(a) The Director of the Department of Social Services or his or her designee;

(b) The Director of the Department of Health and Senior Services or his or her designee;

(c) The Director of the Department of Mental Health or his or her designee;

(d) Four members of the House of Representatives, including two from each political party;

(e) Four members of the Senate, including two from each political party; and

(f) Five members from the Missouri health care community who must be appointed by the Governor with Senate approval;

(45) Requires the task force to make recommendations in a report to the General Assembly on improvements that can be made to the state medical assistance health care delivery system. The report must include, but not be limited to:

(a) Advice on more efficient and cost-effective ways to provide coverage for MO HealthNet participants;

(b) An evaluation of how coverage for MO HealthNet participants can resemble that of commercially available health plans while complying with federal Medicaid requirements;

(c) Possibilities for promoting healthy behavior by encouraging patients to take ownership of their health care and seek early preventative care;

(d) Advice on the best manner in which to provide incentives, including a shared risk and savings to health plans and providers to encourage cost-effective delivery of care; and

(e) Ways that individuals who currently receive medical care coverage through the MO HealthNet Program can transition to obtaining their health coverage through the private sector;

(46) Requires the task force to meet at least quarterly and annually submit by December 31 its recommendations and statewide plan for improvements to the MO HealthNet plan to the Governor, General Assembly, and Director of the Department of Social Services. Members of the task force cannot receive any additional compensation but must be eligible for reimbursement for expenses directly related to the performance of task force duties; and

(47) Specifies that the provisions concerning the task force expire May 31, 2024.

PROPONENTS: Supporters say that health care providers need stability and predictability in the system, which the bill provides while promoting reforms in the reimbursement system. The bill allows recipients to participate in their care and make choices. Health care homes are a good tool for managing cost, and significant savings should result from the management of emergency room use.

Testifying for the bill were Representative Barnes; BJC Healthcare; Missouri Chamber of Commerce and Industry; Catholic Charities Archdiocese of St. Louis; Missouri Pharmacy Association; Missouri Ambulance Association; Monsignor Gregory Higley, Missouri Catholic Conference; Missouri Hospital Association; Campaign Life Missouri; St. Louis Area Business Health Coalition; Associated Industries of Missouri; Kerry L. Noble, Pemiscot Memorial Health Systems; Missouri Primary Care Association; Missouri Coalition of Community Mental Health Centers; and Saint Luke's Health System.

OPPONENTS: Those who oppose the bill say that the elimination of coverage for the blind pension is troubling. It would be prudent to wait to change the Children's Health Insurance Plan (CHIP) until the federal reauthorization occurs.

Testifying against the bill were Partnership for Children; National MS Society; Missouri Budget Project; Cynthia Keele and John Orear, NAMI Missouri; Wayne Lee; American Cancer Society; Planned Parenthood Affiliates in Missouri; and Ed Weisbart, Consumer Council.

OTHERS: Others testifying on the bill say that Section 1115

federal waivers are widely used for innovation and Section 1396a for categorical eligibility, but not to the extent of the matching rate. The United States Secretary of Health and Human Services does not have the authority to provide the enhanced matching rate at less than 138% percent of the poverty level.

Testifying on the bill were Joel Ferber, Legal Services of Eastern Missouri; and Sidney Watson, St. Louis University School of Law.