FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 90

96TH GENERAL ASSEMBLY

0752L.02C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 103.080, 103.089, and 192.300, RSMo, and to enact in lieu thereof seven new sections relating to health care policies, with a penalty provision.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 103.080, 103.089, and 192.300, RSMo, are repealed and seven new sections enacted in lieu thereof, to be known as sections 103.080, 103.082, 103.089, 191.774, 192.300, 376.1226, and 376.1227, to read as follows:

103.080. 1. As used in this section, the following terms shall mean:

(1) "Health savings account" or "account", shall have the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended;

(2) "High deductible health plan", a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

2. Beginning with the open enrollment period for the 2009 plan year, the board shall offer to all qualified state employees and retirees, in addition to the plans currently offered including but not limited to health maintenance organization plans, preferred provider organization plans, copay plans, and participating public entities the option of receiving health care coverage through a high deductible health plan and the establishment of a health savings account. **[**In no instance shall a qualified employee or retiree be required to enroll in a high deductible health plan with a deductible greater than the minimum allowed by law, however, a qualified employee or retiree shall have the option to enroll in a high deductible health plan up to the maximum allowed by law.**]** The health savings account shall conform to the guidelines to be established by the Internal Revenue Service for the **[**2009**] current** tax year but in no case shall a qualified employee or retiree be required to contribute more than the minimum amount

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

allowed by law. A qualified employee or retiree may contribute up to the maximum allowed by law. In order for a qualified individual to obtain a high deductible health plan through the Missouri consolidated health care plan, such individual shall present evidence, in a manner prescribed by regulation, to the board that he or she has established a health savings account in compliance with 26 U.S.C. Section 223, and any amendments and regulations promulgated thereto.

3. **Beginning with the open enrollment period for the 2012 plan year, the high deductible health plan offered under subsection 2 of this section shall have monthly subscriber premiums that are materially lower than nonhigh deductible health plan monthly subscriber premiums with a goal of monthly subscriber premiums being at least fifty percent lower than nonhigh deductible health plan premiums. The amount of the annual deductible for the high deductible health plan offered under subsection 2 of this section shall be no greater than two hundred percent of the minimum annual deductible for self-only coverage and family coverage as established by the Internal Revenue Service for the current tax year. The coverage afforded by the high deductible health plan, after the applicable deductible has been met, shall be substantially similar or better than the average coverage provided by the nonhigh deductible health plans.**

4. It is the intent of the Missouri general assembly to promote the use of consumer-driven health care plans such as health savings account compatible high deductible health plans by active state employees as an alternative to using traditional managed care plans. If, after the completion of the open enrollment period for the 2012 plan year, fewer than ten percent of Missouri's active state employees have enrolled in a high deductible health plan described in this section, then the board shall offer a more competitive high deductible health plan with increased financial and coverage incentives, including but not limited to alternative annual deductibles, out-of-pocket expenses, and other health plan design features, all within the established federal guidelines, with the goal of having forty percent of Missouri's active state employees enrolling in a health savings account compatible high deductible health plan by the open enrollment period for the 2015 plan year.

5. The board is authorized to promulgate rules and regulations for the administration and implementation of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

[4.**]** **6.** The board shall issue a request for proposals from companies interested in offering a high deductible health plan in connection with a health savings account.

103.082. 1. Beginning on a date specified by the board but not later than January 1, 2013, the board shall develop a cost-neutral or cost-positive plan for providing bariatric coverage for persons insured under the Missouri consolidated health care plan.

2. The board may adopt rules necessary to implement the provisions of this subsection. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2011, shall be invalid and void.

103.089. Participants in the program of medical benefits coverage provided by sections 103.003 to 103.175 who are eligible for Medicare benefits and who are not eligible for the program of medical benefits coverage provided under sections 103.083 to 103.098 to be their primary plan of coverage benefits shall be provided **[**the same**]** **substantially similar** benefits provided participants who are not eligible for Medicare benefits. Medical benefits coverage provided under sections 103.003 to 103.175 shall be coordinated with Medicare benefits for participants covered by part A or part B, or both, of Medicare benefits, or **for participants eligible for but not covered by part A or part B, or both, of Medicare benefits,** reduced by an amount determined by the claims administrator to provide a benefit equivalent to the amount which would be provided on a coordination of benefit basis for **such** participants **[**not**]** **if such participants were** covered by part A or part B, or both, of Medicare benefits. As used in sections 103.083 to 103.098, the term "Medicare benefits" shall include those medical benefits provided by Title XVIII, A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. section 301, et seq.) and amendments thereto. Any participating member agency having employees or eligible retirees not covered by Medicare shall authorize the plan at its option to enroll those individuals for medical benefits as provided by Title XVIII, A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act whenever they become eligible for such benefits and the plan shall pay the premium for such enrollment on behalf of that person. The Medicare premium amounts shall be included in the rate established by the actuary for providing medical benefits coverage to such a participating member agency. Anyone not authorizing this Medicare enrollment shall be denied coverage.

191.774. 1. No person shall smoke or otherwise use tobacco products in any area of a state correctional center or the grounds thereof. Any person who violates the provisions of this section is guilty of an infraction.

2. The provisions of this section shall become effective July 1, 2013.

192.300. **1. Except as otherwise provided in subsection 2 of this section,** the county commissions and the county health center boards of the several counties may make and promulgate orders, ordinances, rules or regulations, respectively as will tend to enhance the public health and prevent the entrance of infectious, contagious, communicable or dangerous diseases into such county, but any orders, ordinances, rules or regulations shall not be in conflict with any rules or regulations authorized and made by the department of health and senior services in accordance with this chapter or by the department of social services under chapter 198. The county commissions and the county health center boards of the several counties may establish reasonable fees to pay for any costs incurred in carrying out such orders, ordinances, rules or regulations, however, the establishment of such fees shall not deny personal health services to those individuals who are unable to pay such fees or impede the prevention or control of communicable disease. Fees generated shall be deposited in the county treasury. All fees generated under the provisions of this section shall be used to support the public health activities for which they were generated. After the promulgation **[**and**] ,** adoption**, and approval if required under subsection 2 of this section,** of such orders, ordinances, rules or regulations by such county commission or county health board, such commission or county health board shall make and enter an order or record declaring such orders, ordinances, rules or regulations to be printed and available for distribution to the public in the office of the county clerk, and shall require a copy of such order to be published in some newspaper in the county in three successive weeks, not later than thirty days after the entry of such order, ordinance, rule or regulation. Any person, firm, corporation or association which violates any of the orders or ordinances adopted, promulgated and published by such county commission is guilty of a misdemeanor and shall be prosecuted, tried and fined as otherwise provided by law. The county commission or county health board of any such county has full power and authority to initiate the prosecution of any action under this section.

2. In any county of the third classification with a township form of government and with more than twenty-one thousand nine hundred fifty but fewer than twenty-two thousand nine hundred fifty inhabitants, any order, ordinance, rule or regulation made and promulgated by a county health center board must be approved by the county commission.

376.1226. 1. No contract between a health carrier or health benefit plan and a dentist for the provision of dental services under a dental plan shall require that the dentist

provide dental services to insureds in the dental plan at a fee established by the health carrier or health benefit plan if such dental services are not covered services under the dental plan.

2. For purposes of this section, the following terms shall mean:

(1) "Covered services", services reimbursable by a health carrier or health benefit plan under an applicable dental plan, subject to such contractual limitations on benefits as may apply, including but not limited to deductibles, waiting periods, or frequency limitations;

(2) "Dental plan", any policy or contract of insurance which provides for coverage of dental services;

(3) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(4) "Health carrier", the same meaning as such term is defined in section 376.1350.

376.1227. 1. No contract between a health carrier or health benefit plan and an optometrist for the provision of optometric services under a vision plan shall require that the optometrist provide optometric services to insureds in the vision plan at a fee established by the health carrier or health benefit plan if such optometric services are not covered services under the vision plan.

2. For purposes of this section, the following terms shall mean:

(1) "Covered services", services reimbursable by a health carrier or health benefit plan under an applicable vision plan, subject to such contractual limitations on benefits as may apply, including but not limited to deductibles, waiting periods, or frequency limitations;

(2) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Vision plan", any policy or contract of insurance which provides for coverage of vision care services.

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